



# AMERICAN MARITIME OFFICERS MEDICAL PLAN

## SUMMARY PLAN DESCRIPTION

### GROUP 1 - AMO

- Type A – Active Benefits
- Type B – Pensioner Not Medicare Eligible Benefits
- Type C – Pensioner Medicare Eligible Benefits
- STM – Similar to Medicare

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**LETTER FROM THE BOARD OF TRUSTEES**  
**AMERICAN MARITIME OFFICERS MEDICAL PLAN**

Dear Participants:

The Trustees of the American Maritime Officers (AMO) Medical Plan are pleased to present you with this updated booklet summarizing your benefits under the AMO Medical Plan. This booklet is referred to as the Plan's Summary Plan Description (the "SPD"). The SPD is intended to outline the principal provisions of the Plan so that you may know your rights and duties under the Plan. **The Trustees reserve the right to amend, modify or terminate the Plan, in whole or in part, at any time and for any reason.** You will be notified of any changes.

**Please remember that this SPD does not provide you with the full details of the Plan nor does it change the written Plan document that determines your rights under the Plan. A copy of the Plan document is available upon request from the Plan Office. If there is a conflict between the official Plan document and this SPD, the language of the Plan document will govern.**

Please note that no one except the Board of Trustees (or its designees) has the authority to interpret and construe the terms of the Plan, including this booklet and the other official Plan documents, to make any promises to you about it, or to change the provisions of the Plan. The Board of Trustees has the exclusive right and power, in its sole and absolute discretion, to interpret the Plan documents and decide all matters under the Plan, including, without limitation, the right to make all decisions with respect to eligibility for and the amounts of benefits payable under the Plan and the right to resolve any possible ambiguities, inconsistencies or omissions concerning the fund or the Plan. All determinations of the Board of Trustees (or its duly authorized designees) are final and binding on all persons and will be given full force and effect.

Please read this booklet carefully and retain it for future reference. If you have any questions, the Plan Office will be pleased to help you.

Sincerely,

BOARD OF TRUSTEES

**BOARD OF TRUSTEES  
AMERICAN MARITIME OFFICERS (AMO) MEDICAL PLAN**

<b>UNION TRUSTEES</b>	<b>EMPLOYER TRUSTEES</b>
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<p>Joseph Gremelsbacker National Vice President/Deep Sea American Maritime Officers 2 West Dixie Highway Dania Beach, FL 33004</p>	<p>Robert Rogers Vice President Interocean American Shipping Corporation Echelon II Plaza 221 Laurel Road, Suite 300 Voorhees, NJ 08043-2349</p>
<p>Donald Cree National Vice President/Great Lakes American Maritime Officers One Maritime Plaza Toledo, OH 43604</p>	<p>Kevin McMonagle Vice President, Human Resources and Risk Management American Steamship Company 500 Essjay Road Williamsville, NY 14221</p>
<p>Donald Nilsson National Executive Board Member/Deep Sea American Maritime Officers 652 Fourth Avenue Brooklyn, NY 11232</p>	
<b>ALTERNATE UNION TRUSTEES</b>	<b>ALTERNATE EMPLOYER TRUSTEES</b>
<p>Robert Kiefer National Assistant Vice President At Large American Maritime Officers 2604 S. 4<sup>th</sup> Street Philadelphia, PA 19148</p>	<p>John Dragone Vice President, Operations OSG Ship Management 302 Knights Run Avenue, Suite 1200 2 Harbour Island Tampa, FL 33602</p>
<p>Daniel Shea National Executive Board Member At Large American Maritime Officers 1121 7<sup>th</sup> Street, Second Floor Oakland, CA 94607</p>	<p>Edward Hanley Vice President, Labor Relations Maersk Line Ltd. One Commercial Place 20<sup>th</sup> Floor Norfolk, VA 23510-2103</p>
<p>David Weathers National Executive Board Member At Large American Maritime Officers 13730 FM 3005, Suite 170 Galveston, TX 77554</p>	

# AMERICAN MARITIME OFFICERS (AMO) MEDICAL PLAN SUMMARY PLAN DESCRIPTION

## GENERAL INFORMATION

### TYPE OF PLAN

The American Maritime Officers (AMO) Medical Plan, frequently referred to as the AMO Medical Plan, is a multiemployer benefit plan. The following is a summary of the current Group 1 benefits provided under the AMO Medical Plan. These benefits are divided into four Plan Types: Active Benefits, Pensioner Not Medicare Eligible Benefits, Pensioner Medicare Eligible Benefits and Similar to Medicare Benefits.

The purpose of this summary is to convey important information and is not intended to interpret, extend or change in any way the Rules and Regulations of the Plan, which will govern in all cases.

### PLAN ADMINISTRATION

A joint Board of Trustees administers the Plan. The names of current Trustees are on page 7. The Board of Trustees reserves the right to modify, amend or terminate the benefits provided under the AMO Medical Plan at any time and for any category. Benefits under the AMO Medical Plan are not vested.

The Plan is maintained pursuant to collective bargaining agreements between the Union and its affiliates and their contracted companies. A complete list of contracted companies and copies of applicable agreements may be obtained upon written request by participants and beneficiaries to the Director of Benefits and are available for examination, upon written request, at the locations listed on page 10. Participants are also entitled to receive, free of charge, information as to whether a particular employer is a contracted company (also referred to as a participating employer) of the AMO Medical Plan.

### FUNDING OF THE PLAN - CONTRIBUTIONS

The contracted companies or participating employers make contributions to the Medical Plan on behalf of their employees (also referred to as participants). The amounts of the contributions, which are based on days of employment, are negotiated as collective bargaining agreements are renewed. All contributions received are deposited in banks insured by the Federal Deposit Insurance Corporation. The Plan's records are regularly audited by independent certified public accountants. An annual financial report of the Plan's activities is filed with the U.S. Department of Labor and a summary of the report is published in the Union newspaper.

Contributions to the AMO Medical Plan, which has been granted tax-exempt status, are paid out as benefits to eligible participants and their dependents, and for administrative expenses. Those contributions that are not paid out in the form of current benefits and expenses are accumulated and kept in reserve for future benefit payments. No covered participant, nor his designated beneficiaries, dependents, or estate, has a vested right in or to the fund or any part thereof.

## PLAN DESCRIPTION

NAME OF PLAN:	American Maritime Officers (AMO) Medical Plan
NAME, ADDRESS AND TELEPHONE NUMBER OF BOARD OF TRUSTEES:	Board of Trustees American Maritime Officers Medical Plan 2 West Dixie Highway, Dania Beach, FL 33004 (954) 920-4247 or (800) 348-6515
EMPLOYER ID NUMBER:	13-5600786
PLAN NUMBER:	501
PLAN YEAR:	October 1 – September 30
TYPE OF PLAN:	Medical Benefits
TYPE OF ADMINISTRATION:	Trustee Administered
PLAN ADMINISTRATOR:	Board of Trustees American Maritime Officers Medical Plan 2 West Dixie Highway, Dania Beach, FL 33004 (954) 920-4247 or (800) 348-6515
REINSURANCE CARRIER:	Standard Security 485 Madison Avenue New York, NY 10022

*The Board of Trustees welcomes your questions and encourages participants and their families to make inquiries directly to the Plan Office. The Plan Office is located at 2 West Dixie Highway, Dania Beach, Florida 33004. The Administrator is the agent for service of legal process. Process may be served on the Administrator at the Plan Office. Service of legal papers may also be made upon a Plan Trustee.*

## OBTAINING INFORMATION AND FORMS

Information and forms may be obtained by contacting the Plan office at the following location:

AMO Medical Plan  
2 West Dixie Highway  
Dania Beach, FL 33004  
(954) 920-4247 or (800) 348-6515

Forms may also be obtained via the Plan's web site: [www.amoplans.com](http://www.amoplans.com)

## COPIES OF PLAN DOCUMENTS

Copies of Plan documents will be made available for review at the following AMO offices upon written request to the Director of Benefits or the Union:

652 Fourth Avenue, Brooklyn, NY 11232  
(800) 545-9589

2 West Dixie Highway, Dania Beach, FL 33004  
(800) 348-6515

13730 FM 3005, Suite 170, Galveston, TX 77554  
(800) 362-0513, Ext. 2001

1121 7th Street, Second Floor, Oakland, CA 94607  
(510) 444-5301 OR (800) 362-0513 Ext. 5001

1 Maritime Plaza, Toledo, OH 43604  
(419) 225-3940 or (800) 221-9395

2604 South 4th Street, Philadelphia, PA 19148  
(800) 362-0513, Ext. 4001

490 L'Enfant Plaza East, S.W., Suite 7204, Washington, DC 20024  
(800) 362-0513, Ext. 7001

## DEFINITIONS

### **ACUTE DRUGS**

The term “acute drugs” means medications prescribed by a legally qualified physician for short-term treatment.

### **CASE MANAGEMENT**

The term “case management” means services provided by the AMO Medical Plan team or CIGNA CareAllies consisting of professionals, including an MD, RN, ARNP and Coordinator. A listing of services provided can be found on page [36](#).

### **CO-INSURANCE**

The term “co-insurance” means a percentage of eligible medical expenses shared by the participant and/or dependent and the Plan after deductibles and co-payments have been met.

### **CO-INSURANCE MAXIMUM**

The term “co-insurance maximum” means the maximum amount of co-insurance paid by the participant and/or dependent during a calendar year.

### **CONTRACTED RATES**

The term “contracted rates” means the rates providers and facilities in a PPO network have agreed to accept as payment for treatment of participants and dependents.

### **CO-PAYMENT OR CO-PAY**

The term “co-payment” or “co-pay” means a pre-determined dollar amount or percentage of eligible expenses that the participant and/or dependent are required to pay.

### **DEDUCTIBLE**

The term “deductible” means a certain dollar amount of eligible expenses that the participant and/or dependent are required to pay before benefits are paid.

### **DEPENDENT**

The term “Dependent” means a:

- **Child**
  - Each child of a participant who is under nineteen years of age and unmarried.
  - Each unmarried child of a participant who is nineteen years but less than twenty-three years of age attending school on a full time basis and dependent upon the participant for principal support and maintenance. School vacation periods during any calendar year that interrupt but do not terminate what otherwise would have been a continuous course of study in that calendar year shall be considered a part of school attendance on a full-time basis. For the purpose of this section, full-time shall mean the completion of twelve (12) credit hours per semester or its equivalent. Credits completed during summer or winter sessions may be applied to any one semester in a scholastic year.
  - The coverage of an unmarried child will not cease because of attainment of the termination age above while the participant's coverage is in force and the child otherwise qualifies as a dependent, if the child is incapable of self-sustaining employment by reason of total disability as defined by the Social Security Administration, and is dependent upon the participant for principal support and maintenance, and became incapable prior to attainment of the determination age specified above.

Child also includes:

- a legally adopted child from the time the child is placed for adoption;
- a stepchild, a child under legal guardianship, or a child under legal custody who is a member of the participant's household and dependent upon him for support;

## DEFINITIONS (Continued)

- **Spouse**
  - A spouse of a participant, provided that any benefit payable with respect to such spouse shall cease upon the date of divorce or legal separation from the participant.
- **Parent(s) or Stepparent(s)**
  - Parents or stepparents of an unmarried participant, who are dependent upon the participant for principal support and maintenance, provided the participant has no other dependents or former dependents that are or were at any time eligible for coverage under this Plan. A dependent parent or stepparent must be listed as a dependent on the participant's annual tax return and have earnings less than the maximum amount permitted to be earned by Social Security within a full calendar year. In addition, a dependent parent or stepparent must not be eligible to participate in any national, state or other governmental plan of health insurance or care including Medicare and Medicaid.

### **EMERGENCY TREATMENTS**

The term "emergency treatments" means treatments for life threatening situations for which immediate medical attention is required.

### **EXPERIMENTAL TREATMENTS**

The term "experimental treatments" means treatments that are considered experimental by the Federal Medicare Program.

### **HOSPITAL CONFINEMENT**

The term "hospital confinement" means confinement in a hospital as a registered inpatient on the advice of the patient's physician. Successive periods of confinement for the same illness or injury will be considered the same confinement unless separated by a period of sixty (60) days.

### **INCIDENT**

The term "incident" means a definite and separate illness or injury requiring a procedure or treatment.

### **INELIGIBLE EXPENSES**

The term "ineligible expenses" means charges incurred which are not covered under the Rules and Regulations of the AMO Medical Plan.

### **IN-NETWORK**

The term "in-network" means within a contracted PPO network. "In-network providers" and "in-network facilities" are providers and facilities within a contracted PPO network. "In-network benefits" are benefits paid as a result of a participant using a provider or facility within a contracted PPO network.

### **LEGALLY CONSTITUTED HOSPITAL**

The term "legally constituted hospital" means a hospital or division of a hospital that keeps patients regularly overnight, has full diagnostic and therapeutic facilities under the supervision of a staff of duly licensed physicians and that regularly provides 24-hour nursing services by Registered Nurses.

### **LEGALLY QUALIFIED PHYSICIAN**

The term "legally qualified physician" means only a person who is duly licensed to:

- prescribe and administer any and all drugs, or
- perform surgical procedures, or
- who only for payment of chiropractic benefits is a Doctor of Chiropractic, or
- who only for obstetrical care is a certified nurse midwife, or
- who only for treatment of a psychiatric disorder shall also include a mental health practitioner who is duly licensed or certified by the State, or
- who only for therapeutic treatment shall also include a practitioner who is duly licensed or certified by the State.

## DEFINITIONS (Continued)

- For purposes of recommending and approving a hospital admission, the term "legally qualified physician" shall mean only a Medical Doctor (MD) or Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

### **MAINTENANCE DRUGS**

The term "maintenance drugs" means drugs prescribed by a legally qualified physician and used for a chronic condition and taken frequently for a long period of time. Maintenance drugs are classified in accordance with the prevailing database supplied to the Plan by its contracted Pharmacy Benefit Manager.

### **MEDICAL EMERGENCY**

The term "medical emergency" means the sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child, impairment of a bodily function or dysfunction to any bodily organ or part.

Example: (included but not limited to) chest pain, difficulty breathing, uncontrolled bleeding, sudden severe pain, trauma, etc.

### **MEDICALLY NECESSARY**

The term "medically necessary" means treatment recommended and approved by a legally qualified physician and commonly and customarily recognized throughout such physician's profession as appropriate treatment for the particular injury or disease.

### **OUT-OF-NETWORK**

The term "out-of-network" means outside of a contracted PPO network. "Out-of-network providers" and "out-of-network facilities" are providers and facilities not within a contracted PPO network. "Out-of-network benefits" are benefits paid as a result of a participant using a provider or facility outside of a contracted PPO network.

### **OUTPATIENT HOSPITAL SERVICES**

The term "outpatient hospital services" means medical services performed at an outpatient hospital facility.

### **PARTICIPANT**

The term "participant" means an employee or pensioner covered under the Plan. The term "active participant" means an employee (not pensioner) covered under the Plan.

### **PENALTY**

The term "penalty" means a reduction in benefits due to non-compliance with the pre-certification requirements of the Plan (see Failure to Pre-Certify on page [37](#)).

### **PENSIONER**

The term "Pensioner" means a former employee receiving a pension from the AMO Pension Plan or from an Inland Waters Company Pension Plan and who at the time of his retirement (and at the time he received an in-service lump sum distribution, if applicable) was employed by a company obligated to make contributions to this Plan on his behalf. In the case of an in-service lump sum distribution, the employee becomes a pensioner on the date active coverage terminates provided he files a declaration of retirement while eligible for active coverage. In the case of a pensioner who returns to covered employment, he will again become a pensioner on the date active coverage terminates (see Duration of Eligibility on page [15](#) and Termination of Eligibility on page [16](#)). The term "pensioner" also means certain retired employees of the American Maritime Officers Plans, the American Maritime Officers and American Maritime Officers Service receiving a D2A TTWISEU Pension and Severance pension with at least 20 years of pension credit (under the D2A Plan or D2A and AMO Plans combined) and who had Group I coverage under this Plan on the pension effective date.

## DEFINITIONS (Continued)

### **PHYSICIAN'S OFFICE VISIT**

The term "physician's office visit" means a visit to a family practitioner, specialist, OB/GYN or pediatrician.

### **PPO**

The term "PPO" means a preferred provider organization with which the Plan has an agreement to provide health care services to participants and their dependents through the PPO's network of providers and facilities.

### **PROFESSIONAL MEDICAL VISIT**

The term "professional medical visit" means a visit to or by a mental health practitioner, therapist, chiropractor, emergency room physician or urgent care physician.

### **SPECIALTY DRUG TREATMENT**

The term "specialty drug treatment" means all drug programs, drug treatments and drug therapies associated with a chronic or critical illness/condition including, but not limited to, chemotherapy, IV infusion therapies and treatment of hepatitis-C and HIV.

### **SURGERY**

The term "surgery" means treatment of a disease or injury by operative procedures. The term "therapeutic surgery" means a procedure to repair damage, arrest disease or treat a condition.

### **URGENT CARE**

The term "urgent care" means treatment for a medical illness or injury that is serious, but not serious enough to warrant emergency treatment.

### **USUAL, CUSTOMARY AND REASONABLE (UCR)**

The term "Usual, Customary and Reasonable" means a charge that does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies for a similar disease or injury. The term "locality" means a county or such greater area as is necessary to establish a representative cross section of persons or other entities regularly furnishing the type of treatment, services or supplies for which the charge is made. Where services are performed by a provider outside of the United States, UCR means the prevailing rate for the Dania Beach, Florida area.

# **BENEFIT ELIGIBILITY**

## **BASIC ELIGIBILITY**

A participant establishes initial eligibility for benefits on the date he or she completes 90 days of Covered Employment within a period of any 182 consecutive days. A participant who then loses eligibility will re-establish eligibility for benefits on the date he or she completes thirty 30 days of Covered Employment within a period of 182 consecutive days. (Note: Eligibility for Administrative, Union and certain other employees is established on the date the participant completes 30 days of Covered Employment).

"Covered Employment" includes the following:

- days of actual employment with companies signatory to the AMO Medical Plan;
- days of paid vacation from the AMO Vacation Plan for Deep Sea employment, provided 30 or more days of actual shipboard employment are completed within the immediately preceding six consecutive months;
- days the participant receives unearned wages from a Deep Sea company and for which the company makes contributions to this Plan;
- days of Disability for which the participant receives Disability Benefits (Accident and Sickness Benefits) from this Plan;
- days of participation as an observer under the Observer Training Program sponsored by the American Maritime Officers Safety and Education Plan;
- days of company paid sick leave as reported to the AMO Medical Plan by Great Lakes Area contributing Employers and for which the company makes contributions to this Plan;
- days of family leave for Great Lakes employment and for which the company makes contributions to this Plan.

For Inland Waters and Great Lakes Tugboat employees who are scheduled for a specified number of days on and off a covered vessel, ninety (90) days of Covered Employment for initial eligibility purposes will include scheduled days off provided the participant returns to a covered vessel at the conclusion of the scheduled days off.

For those Inland Waters employees who are considered permanent relief employees, 1½ days of eligibility will be granted for each day of actual shipboard employment.

## **DURATION OF ELIGIBILITY**

Unless terminated earlier:

- Group 1 Deep Sea, Great Lakes and Inland Water participants remain eligible for benefits for 182 consecutive days following their last date of Covered Employment.
- Administrative, Union, and certain other employees remain eligible for 30 days following their last date of Covered Employment (or as otherwise provided in the applicable Collective Bargaining Agreement).
- Pensioners who return to Covered Employment and meet the eligibility requirements for active benefits will terminate active eligibility on their last date of Covered Employment.

## **LEAVE OF ABSENCE FOR MILITARY SERVICE**

A participant on qualified military duty for 31 days or less will continue to receive health coverage for up to 31 days in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are on active duty for more than 31 days, USERRA permits you to continue medical coverage for you and your dependents at your own expense for up to 24 months (effective for elections on or after December 10, 2004). This continuation right operates in the same way as COBRA. In addition, your dependent(s) may be eligible for health care coverage under the Civilian Health & Medical Program of the Uniformed Services (CHAMPUS).

When you are discharged (not less than honorably) from service in the uniformed services, your full eligibility will be reinstated on the day you return to work with a contributing employer, provided that you return to employment within:

- 90 days from the date of discharge if the period of service was more than 180 days; or
  - 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days;
- or

- at the beginning of the first available working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

### **TERMINATION OF ELIGIBILITY**

Eligibility for active participants terminates on the earliest of:

- the date coverage through Covered Employment (see page 15) terminates; or
- the date the participant enters qualified military service, except if a participant is in service for 31 days or less; or
- the effective date of pension from the American Maritime Officers Pension Plan (participants and their families may be eligible for Pensioner's benefits provided they meet the eligibility requirements as outlined on page 34), or
- in the case of a Pensioner who returns to Covered Employment as permitted under the AMO Pension Plan Rules and Regulations, the date following his last date of Covered Employment; or
- in the case of an In-Service Lump Sum recipient, 182 days after his last date of Covered Employment (participants and their families may be eligible for Pensioner's benefits provided they meet the eligibility requirements as outlined on page 34 and provided a Declaration of Retirement has been received in the Plan Office prior to termination of Active coverage); or
- the date the participant's employer ceases to be obligated under a Collective Bargaining Agreement with the Union, covering the unit of employees to which the employee belongs to make the required contributions to the AMO Medical Plan on the participant's behalf; or
- the date the participant commences employment with an Employer in the industry who is not party to a Collective Bargaining Agreement; or
- for Administrative, Union and Certain Other Employees, 30 days after the last day of a period of 30 days or more of Covered Employment (or as otherwise provided in the applicable Collective Bargaining Agreement); or
- the date a determination is made that a participant or dependent filed a fraudulent claim or intentionally misstated or concealed material facts relating to a claim for benefits of any type under the Plan; or
- the date an eligible dependent parent(s) or stepparent(s) becomes eligible to participate in any national, state or other governmental plan of health insurance or care, including Medicare and Medicaid; or
- the date an eligible dependent ceases to meet the Plan's definition of dependent (see pages 11 and 12).

### **ELIGIBILITY FOR INCREASED BENEFITS**

In order to be eligible for any increased benefits, a participant must be actively at work on or after the date such increase becomes effective. Actively at work means days of active employment with an employer signatory to the AMO Medical Plan.

### **CHANGES IN DEPENDENT STATUS**

In the event that a participant has a change in dependent status, as listed below, the following documentation, as well as an updated Permanent Data Form, will be required:

<b>Status Change</b>	<b>Proof Required</b>
Birth	Birth certificate
Marriage	Marriage license
Divorce	Divorce Decree
Death of Dependent	Death certificate
Adoption	Adoption papers
Foster Child or Child Under Legal Guardianship	Court documentation
Parent or Stepparent of unmarried Participant	Affidavit of Support for Dependent Parent, copy of annual tax return as filed with the IRS of participant and dependent parent.

#### **Adding Dependents**

A participant may add a dependent by completing a Permanent Data Form that can be obtained from the Plan Office. The Plan makes use of the Permanent Data Form for two purposes: (1) to identify dependents and (2) to verify demographic data. Documentation as outlined above is required.

#### **Removing Dependents**

If, while covered under the Plan, a participant becomes divorced or legally separated, or if a dependent child ceases to be eligible as a dependent under the Rules and Regulations of the Plan, the spouse's or

child's coverage terminates. Continued coverage may be elected by the spouse and/or dependent children for up to 36 months. The participant or his/her dependents must notify the Plan Administrator within 60 days of the change of status. See "Continuation of Medical Coverage (COBRA)" on page [17](#) for details. Documentation as outlined above is required.

### **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**

A Qualified Medical Child Support Order ("QMCSO") is a medical child support order ("MCSO") that recognizes the child of a participant as having the right to receive benefits under a group health plan. Once a QMCSO has been received, the Plan Administrator will determine if it is a qualified order. If the order is determined to be QMCSO, the Plan will ensure that the child is treated as a dependent under the Plan to the extent required by the order and consistent with the Plan's Rules and Regulations. The Plan's procedures for determining whether a MCSO is a qualified order will be made available to participants and beneficiaries free of charge upon request.

### **CERTIFICATE OF CREDITABLE COVERAGE**

When coverage ends, you and/or your covered dependents are entitled by law to, and will be provided with, a certificate of creditable coverage. The certificate indicates the period of time you and/or your dependent(s) were covered under the Plan (including COBRA coverage), as well as certain additional information required by law. This certificate may be necessary if you and/or your dependent(s) become eligible for coverage under another group health plan or if you buy yourself and/or your covered dependents a health insurance policy within 63 days after your coverage under this Plan ends. The certificate is necessary because it may reduce any exclusion for preexisting conditions that may apply to you and/or your covered dependents under the new group health plan or health insurance policy.

This certificate will be provided to you shortly after the Plan knows that coverage (including COBRA coverage) for you and/or your dependents has ended, and may also be provided if the Plan office receives a request for same within two years after the last date of your coverage. The certificate will be sent out by first class mail shortly after your coverage under this Plan ends. If you elect COBRA coverage, another certificate will be sent by first class mail shortly after the COBRA coverage ends.

### **CONTINUATION OF MEDICAL COVERAGE (COBRA)**

Federal Law requires that if a participant or participant's dependents lose medical coverage under certain circumstances (called "qualifying events"), they must be given the opportunity to continue coverage under the AMO Medical Plan at their own expense for a limited period of time.

If a participant and dependent's coverage ends due to termination of the participant's employment (except for gross misconduct) or a reduction of hours or days, the participant and/or his dependents may elect to continue coverage for a total of 18 months (29 months if an eligible individual is disabled under the Social Security Act within 60 days of the date of termination). If a dependent loses coverage for any of the following reasons, the dependent may elect to continue coverage for up to 36 months:

- Death of the participant
- Divorce or legal separation
- Loss of benefits because the participant becomes entitled to Medicare, or
- A dependent child exceeds the maximum age for coverage as a dependent.

When the qualifying event is the end of employment or reduction of the employee's hours/days of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours/days of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months from the date of the qualifying event. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

## **CONTINUATION OF MEDICAL COVERAGE (COBRA)**

**(Continued)**

### ***(1) Disability extension of 18-month period of continuation coverage***

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled, and you notify the Director of Benefits in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to receive an extension, you must notify the Director of Benefits in writing and within 60 days of a disability determination by the SSA and prior to the expiration of the 18-month period. You must include a copy of the disability determination from the SSA with your written notice of disability.

### ***(2) Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the date of the original qualifying event, if written notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children (if they are qualified beneficiaries) receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Medicare entitlement is not a qualifying event under the Plan because it does not result in loss of coverage. Consequently, Medicare entitlement following a termination of employment or reduction in hours will not extend COBRA to 36 months for spouses and dependents who are qualified beneficiaries.

The period of extended coverage following a participant's last day of Covered Employment provided under the AMO Medical Plan, if any, will not extend the maximum coverage period required under this provision, but will be credited toward satisfaction of the maximum coverage period.

If any of these events occur, the participant or dependent(s) should contact the Director of Benefits immediately. In order to be entitled to elect continued coverage in the event of divorce, legal separation, or a child ceasing to qualify as a dependent, the participant or the dependent(s) must notify the Director of Benefits within 60 days of the qualifying event.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children. In general, participants and their dependents have 60 days from the later of the date their coverage ends or the date they are notified of their right to continue coverage under the Plan to elect such coverage. However, coverage must begin from the date coverage would have terminated if COBRA had not been chosen.

Continued coverage under the AMO Medical Plan will terminate if any of the following events occur:

- The eligible individual fails to pay the required premium when due;
- The eligible individual obtains coverage under another group health plan, either as an employee or a dependent of an employee, provided such plan does not contain any exclusion or limitation for a preexisting condition of the eligible individual;
- The eligible individual becomes entitled to Medicare;
- The AMO Medical Plan is terminated;
- The participant's employer provides health plan coverage for employees under a different health plan or starts contributing to a different multiemployer health plan; or
- Coverage would terminate under the terms of the Plan for an active employee, such as for fraud.

**CONTINUATION OF MEDICAL COVERAGE (COBRA)**

**(Continued)**

Questions concerning your COBRA continuation coverage rights should be addressed to Participant services at 1-800-348-6515, ext. 12.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site.)

## SUMMARY OF BENEFITS

The AMO Medical Plan provides benefits to participants in four categories or Plan Types:

*Plan Type A - Active employees and eligible dependents*

*Plan Type B – Not Medicare Eligible Pensioners and eligible dependents*

*Plan Type C - Medicare eligible Pensioners and eligible dependents*

*STM – Similar to Medicare Pensioners and eligible dependents*

The following pages contain information regarding the benefits available to AMO Medical Plan participants. A complete Schedule of Benefits, which defines the Plan deductibles, co-payments, co-insurance, limitations, exclusions, pre-authorization and/or utilization review requirements, is located at the back of this book. The Board of Trustees reserves the right to amend, modify or terminate the benefits provided in any category or type.

Benefit payments are based on services rendered by a participating provider (in-network) or by a non-participating provider (out-of-network).

To maximize PPO (Preferred Provider Organization) coverage for our participants, effective January 1, 2008, the Plan has contracted with CIGNA Healthcare. The CIGNA Healthcare network consists of Third Party Vendors (TPVs) to cover certain geographical areas in which the participant and/or dependent(s) live.

When a Plan participant receives services from doctors, hospitals, and healthcare facilities within PPO networks (in-network), the overall result is a higher level of benefits at a reduced cost to both the Plan and the participant.

Each Plan participant always has the choice of hospitals, physicians and other healthcare professionals (referred to collectively as “health care providers”). However, if a health care provider is not part of the PPO network (out-of-network), the result could be a greater cost to the participant, as well as the Plan. A list of participating providers can be found on CIGNA’s website ([www.cignasharedadministration.com](http://www.cignasharedadministration.com)) or by calling the PPO directly.

If, after reviewing the benefit information, you have any questions, feel free to contact our Participant Services department at (800) 348-6515.

# **BENEFITS FOR ACTIVE PARTICIPANTS, PENSIONERS, AND THEIR DEPENDENTS HOSPITAL AND MEDICAL BENEFITS**

The following benefits are available to active participants, pensioners, and their dependents. Hospital and Medical Benefits are subject to the Exclusions and Limitations listed on page [25](#). Please refer to the Schedule of Benefits for your Plan Type for information regarding benefits, deductibles, co-payments, co-insurance, limitations, exclusions and pre-certification requirements for the following benefits.

Not all benefits listed below apply to Similar to Medicare benefits. Please refer to the Schedule of Benefits on page [68](#) for details of that Plan Type.

## **HOSPITAL BENEFITS (SUBJECT TO PPO)**

### **Benefit Types and Applicable Schedules**

- Inpatient Hospital (Schedule A1)
- Outpatient Hospital Services (Schedule A2)
- Rehabilitation (Schedule A4)
- Inpatient Psychiatric, Mental or Nervous Disorder (Schedule B)
- Inpatient Alcohol and Substance Abuse (Schedule C)

### **Covered Items**

- Semi-private room and board
- Private room and board if recommended and approved by a legally qualified physician and deemed medically necessary by the Plan.
- Hospital extras

### **Requirements**

- Pre-certification of medical necessity
- Recommended by Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD) or Doctor of Podiatric Medicine (DPM).
- Facility must meet the Plan's definition of a legally constituted hospital.

### **Exclusions and Limitations (Hospital Benefits)**

- No hospital charges will be considered unless:
  - A room and board charge is made, or
  - Confinement was for at least eighteen (18) consecutive hours, or
  - A surgical procedure was performed, or
  - The charges were for emergency care within twenty-four (24) hours of an accident or urgent emergency medical treatment.
- No payment will be made for:
  - Special nursing services, or
  - Hospital patient convenience items, or
  - Emergency room facility charges when the use of the emergency room is deemed not medically necessary by the Plan.
- All inpatient hospital confinements are subject to a confinement deductible.
- The following outpatient hospital services are subject to an incident co-payment and must be pre-certified by the Plan. This incident co-payment does not apply if the services are performed at a non-hospital affiliated facility or if the service is done as part of pre-admission testing related to a hospital stay and done within 3 days of admission.
  - Outpatient Surgery
  - MRI's
  - All Scans

### **Inpatient Hospital Admission through Emergency Room**

- In the event that a participant receives medically necessary treatment at the emergency room of a hospital or facility outside of a PPO or PPN network and is admitted through the emergency room for an inpatient hospital confinement and receives services performed by out-of-network providers, the Plan will pay benefits for the out-of-network facility and the out-of-network providers subject to the Plan's rate schedule for in-network benefits.

# BENEFITS FOR ACTIVE PARTICIPANTS, PENSIONERS, AND THEIR DEPENDENTS HOSPITAL AND MEDICAL (Continued)

## MEDICAL BENEFITS (SUBJECT TO PPO)

### Benefit Types and Schedules

- Physician's Office Visit (Schedule D1)
- Inpatient Medical Services (Schedule D2)
- Chiropractic Services (Schedule D3)
- Outpatient Surgery (Schedule D4)
- Inpatient Surgery (Schedule D5)
- Home Health & Durable Medical Equipment (Schedule D6)
- Diagnostic, Laboratory and X-ray (Schedule D7)
- Chemotherapy/Radiation (Schedule D8)
- Anesthesia (Schedule D9)
- Urgent Care Services - Clinic Visits (Schedule D10)
- Fertility Treatment (Schedule D11)
- Therapeutic Services – Physical, Occupational, Speech, Cardiac Rehabilitation (Schedule D12)
- Outpatient Medical Services (Schedule D13)
- Preventative Care Benefit—baseline mammogram, annual pap exam, PSA, baseline colonoscopy (Schedule D14)
- Outpatient Psychiatric, Mental and Nervous Disorder Medical Expenses (Schedule E1)
- Inpatient Psychiatric, Mental and Nervous Disorder Medical Expenses (Schedule E2)
- Outpatient Alcohol and Substance Abuse Medical Expenses (Schedule F1)
- Inpatient Alcohol and Substance Abuse Medical Expenses (Schedule F2)
- Hospice Services (Schedule G1)

### Requirements

- Surgical procedures performed in an outpatient hospital or surgical center must be pre-certified by the Plan.
- Inpatient hospitalization requires pre-certification by CIGNA CareAllies (see page [36](#)).
- Home Health and Durable Medical Equipment require a written statement by the attending physician (legally qualified physician) and must be medically necessary and pre-certified by the Plan.
- Diagnostic, x-ray and laboratory tests must be recommended by a legally qualified physician.
- All Psychiatric, Mental and Nervous Disorder and Alcohol and Substance Abuse medical services must be provided by a legally qualified physician, which for this purpose includes a mental health provider who is duly licensed or certified by the State.
- Inpatient Psychiatric, Mental and Nervous Disorder and Alcohol and Substance Abuse medical services must be prescribed by a legally qualified physician during the period of confinement and pre-certified by the Plan.
- Fertility Treatments include both medical services and prescriptions drugs. Treatments must be pre-certified by the Plan and prescribed by a legally qualified physician.
- Fertility Treatments are not available to Plan Type C – Pensioners Eligible for Medicare.
- Therapeutic Services must be pre-certified by the Plan and prescribed by a legally qualified physician, which for this purpose includes a practitioner who is duly licensed or certified by the State
- Preventative Care Benefits
  - Mammogram and related diagnostic services (baseline > 40 years of age)
  - PSA (baseline > 50 years of age)
  - Colonoscopy and related diagnostic services (baseline > 50 years of age)
  - Annual Pap Diagnostic Services
- Hospice Services are for participants with a life expectancy of six (6) months or less and is recommended by a legally qualified physician. Includes coverage for participants who are confined as an inpatient in a Hospital, Skilled Nursing Facility, or Hospice, or who are receiving care on an outpatient basis from a hospice care agency. Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, and homemaker or caretaker services. Services not solely related to the care of the patient, including but not limited to: companion services for patient or other members of the family, transportation, housekeeping, and maintenance of the home.

**Exclusions and Limitations (Medical Benefits)**

- All benefits are subject to the exclusions on page [25](#) and the limitations outlined in the Schedule of Benefits.

**Inpatient Hospital Admission through Emergency Room**

- In the event that a participant receives medically necessary treatment at the emergency room of a hospital or facility outside of a PPO or PPN network and is admitted through the emergency room for an inpatient hospital confinement and receives services performed by out-of-network providers, the Plan will pay benefits for the out-of-network facility and the out-of-network providers subject to the Plan's rate schedule for in-network benefits.

# BENEFITS FOR ACTIVE PARTICIPANTS, PENSIONERS, AND THEIR DEPENDENTS HOSPITAL AND MEDICAL (Continued)

## MEDICAL BENEFITS (NOT SUBJECT TO PPO)

### Benefit Types and Schedules

- Emergency Room (Schedule A3)
- Ground Ambulance Benefit (Schedule K)
- Air Ambulance Benefit (Schedule K1)
- TMJ Benefit (Schedule N)
- Nicotine Delivery Systems Benefit (Schedule O3)
- Dental Injury Expense (Schedule P)
- Orthotics Benefit (Schedule V)

### Requirements

- Ground ambulance benefit must be a professional ambulance service, used locally to or from a hospital, and when related to in-hospital care. Locally means ground transportation only to the nearest facility equipped to handle the medical necessity.
- Air ambulance benefit shall mean a helicopter or fixed wing aircraft used for transporting individuals with life-threatening injuries or conditions necessitating rapid transport to the nearest medical/trauma center (facility) equipped to handle the medical necessity by critical care personnel. Air ambulance benefits will be based on a review of medical necessity and will be based on the cost of transporting the participant an equivalent number of miles by ground transportation.
- Nicotine Delivery Systems benefit is not provided through the prescription drug program. Upon purchase of a Nicotine Delivery System product, a claim (itemized bill and AMO Medical Plan Application for Benefits) should be submitted to the AMO Medical Plan.

### Limitations

- All benefits are subject to the exclusions on page [25](#) and the limitations outlined in the Schedule of Benefits.

## GENERAL EXCLUSIONS AND LIMITATIONS TO ALL MEDICAL AND HOSPITAL BENEFITS

### **No benefit payment will be made for:**

- any surgical procedure not recommended, approved and performed by a legally qualified physician.
- care received without cost under the laws of the United States or of any state or political subdivision; including charges incurred or treatment or services performed at a Marine or Veterans Hospital, or elsewhere at Federal Government expense, unless required by law.
- expenses incurred in connection with disease or injury resulting from declared or undeclared war.
- more than one visit to the same provider for the same condition on the same day.
- refractive surgery, eye refraction or examination, prescription eyeglasses, safety lenses, contact lenses, sunglasses (see Optical Benefit on page [27](#)).
- treatment received in connection with and on or after the date of a therapeutic operation or procedure for which a surgical operation expense was incurred.
- any treatments or services received which are not medically necessary.
- any treatments that are cosmetic (except when necessitated by an accidental bodily injury occurring during a period of eligibility), educational (except initial diabetes training), or experimental.
- any treatment or services relating to any of the following procedures:
  - weight reduction surgery, including but not limited to gastric by-pass, gastric stapling, abdominoplasty, liposuction and lipectomy
  - chelation therapy
  - dermabrasion
  - rhinoplasty
  - rhytidectomy
  - gender orientation
  - surgical procedures for reversal of tubal ligation
  - vasovasostomy (reversal of vasectomy)
  - prognathic or orthognathic surgery, including related osteotomy, except in the case of an eligible dependent child as defined under the Rules, in which case such surgery, including related osteotomy, will be covered up to a maximum of \$15,000 per dependent child per lifetime, subject to the establishment of medical necessity, pre-certification and approval by the Plan.
  - transplants other than corneas, kidneys and skin.
- expenses incurred in connection with the treatment of sexually transmitted diseases and diseases arising from or relating to the illegal use of drugs in excess of \$50,000 per person per lifetime.
- any charges incurred by any covered participant or dependent as a result of:
  - an accidental bodily injury arising out of or in the course of employment; or
  - an illness or disease for which the person is entitled to a benefit under any workers' compensation law or the Jones Act, or other maritime industry or common law; or
  - in the case of Deep Sea, Inland Water and Great Lakes participants, any injury or illness occurring on a vessel;
  - in the case of Deep Sea, Inland Water and Great Lakes participants, the above will be waived for the first \$10,000 of eligible expenses per occupational injury or illness occurring aboard a vessel;
  - in the case of Deep Sea, Inland Water and Great Lakes participants, for services provided on or after January 1, 2006, who reach the \$10,000 maximum benefit as provided above, and who subsequently retire with pensioner medical benefits, the above shall not apply and the Plan shall be authorized to make benefit payments in accordance with the Rules governing pensioner medical benefits.
- dental treatment or procedures necessitated by injury to natural teeth unless as a result of a non-occupational accidental bodily injury occurring during a period of eligibility.
- hearing examination or hearing aid (see Hearing Aid Benefit on page [28](#)).
- the pregnancy of any dependent other than a dependent spouse.
- medications for impotence, oral contraceptives for eligible dependent children, anorexiant, vitamins (of all kinds with or without prescription), medications that are available over the counter, and food supplements.
- any AMO Medical Plan co-payments, co-insurance, deductibles or penalties.
- services performed by a provider who ordinarily resides in the same household with the participant or dependent or who is related by blood, marriage, or legal adoption to the participant or dependent.
- services performed by a massage therapist.
- confinement, treatment or travel charges in connection with convalescent care, custodial care, sanitarium care, or similar care.
- for hospice services: bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services (services not solely related to the care of the patient, including but

not limited to: companion services for patient or other members of the family, transportation, housekeeping, and maintenance of the home).

- expenses for which a claim for benefits is not received in the Plan Office within 365 days of the date of service. In the case of claims for which the Plan provides periodic payments, such claims must be received within 365 days after the last date of each period.

**Benefit payments may be reduced up to \$250 of the otherwise eligible benefit for:**

- expenses incurred for non-emergency hospital admissions, inpatient rehabilitation, surgeries performed in a hospital or surgical center, durable medical equipment, home health care, fertility treatments (including prescription drugs), therapy services or specialty drug treatments that were not pre-certified and approved by the Plan.
- expenses incurred for emergency hospital admissions or emergency surgical procedures of which the Plan was not notified within two business days or were not approved by the Plan.

# BENEFITS FOR ACTIVE PARTICIPANTS, PENSIONERS, AND THEIR DEPENDENTS OTHER BENEFITS

## OPTICAL BENEFITS

### Benefit Types and Applicable Schedules

- Optical Benefit (Schedule R)

### Limitations

- Benefit limited to refractions, prescriptions eyeglasses, prescription safety lenses, prescription contact lenses, prescription sunglasses, and refractive surgery.
- Any unused optical benefit may be carried over from one calendar year to the next, but in no event shall a benefit accumulate for more than two calendar years.
- Benefits for pensioners are those in effect on the effective date of pension unless the Trustees specifically provide otherwise.

### Exclusions and Limitations

- Benefits are subject to the exclusions and limitations outlined in the Schedule of Benefits.

## PRESCRIPTION DRUG BENEFIT

### Benefit Types and Applicable Schedules

- Prescription Drug Benefits (Schedule O1)
- Specialty Drug Treatment Benefit (Schedule O2)

### Requirements

- Prescriptions will be filled with generic drugs, if available, unless the physician specifically requests brand or writes Dispense as Written (DAW). If claimant requests brand when generic is available, he or she is responsible for the difference between the brand and the generic in addition to the 20% co-payment.
- Specialty drug treatments must be pre-certified through the AMO Medical Plan Case Management at (800) 348-6515, Ext. 13 prior to dispensing.
- Prescription drugs purchased at a non-participating pharmacy or if a claimant does not identify himself as a participant of the prescription drug program will be paid at 80% of the otherwise eligible benefit upon submission by the participant of a claim (itemized receipt and claim form) to the prescription drug administrator.
- No more than a thirty (30) day supply of acute drugs or a ninety (90) day supply of maintenance drugs may be filled at a time, except in the case of participants who are at sea in which case a supply not to exceed 182 days can be authorized by the Plan.

### Exclusions and Limitations

- All benefits are subject to the exclusions and limitations outlined in the Schedule of Benefits.
- In the event a Medicare Eligible Pensioner enrolls in any Medicare Part D prescription drug plan or any other qualified Medicare prescription drug plan in any year, prescription drug coverage under the Plan will terminate for that year. Subsequently, on an annual basis, should the Medicare Eligible Pensioner terminate enrollment in any Medicare Part D prescription drug plan or any other qualified Medicare prescription drug plan, he/she will be permitted to reinstate his/her prescription drug coverage under the Plan.

# BENEFITS FOR ACTIVE PARTICIPANTS AND THEIR DEPENDENTS

The following benefits are available to Active participants and their dependents only:

## **HEARING AID BENEFIT**

### **Benefit Types and Applicable Schedules**

- Hearing Aid Benefit (Schedule Q)

### **Requirements**

- A hearing aid benefit is available for expenses incurred for hearing examinations and hearing aid devices.

### **Exclusions and Limitations**

- Benefits are subject to the exclusions and limitations outlined in the Schedule of Benefits.
- Hearing aid benefits are not available to Pensioners and their dependents.

## **DENTAL (DIRECT REIMBURSEMENT) BENEFITS**

### **Benefit Types and Applicable Schedules**

Benefits for expenses incurred for dental services or supplies under a Direct Reimbursement (DR) benefit structure as provided in Schedule T.

### **Requirements**

- Participant and/or covered dependents pay for dental services obtained from a dentist of their choosing.
- Submit receipt and itemized bill to the AMO Medical Plan.

### **Exclusions and Limitations**

The following services are not covered under the DR dental benefit:

- Dental Services that are not necessary.
- Hospitalization or other facility charges.
- Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- Any procedure not performed in a dental setting.
- Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- Services for injuries or conditions covered by Worker's Compensation, Jones Act or other employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- Dental Services otherwise covered, but rendered after the date eligibility terminates, including Dental Services for dental conditions arising prior to the date eligibility terminates.
- Services rendered by a provider with the same legal residence as the participant or dependent or who is a member of participant's or dependent's family, including spouse, brother, sister, parent or child.
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral, upper and lower jaw bone surgery (including that related to the temporomandibular joint).
- Acupuncture, acupressure and other forms of alternative treatment.
- Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- Charges for failure to keep a scheduled appointment.
- Services performed by anyone other than by a legally qualified dentist or physician who is recognized by the law of the State in which treatment is received as qualified to treat the type of sickness or injury causing the expenses, or loss, for which claim is made. This exclusion does not apply when scaling or cleaning of teeth and topical application of fluoride is performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the dentist;
- Dental work resulting from accidental injury.
- Services covered under Medical Benefits.

**BENEFITS FOR ACTIVE PARTICIPANTS  
AND THEIR DEPENDENTS  
(Continued)**

- Any expenses for which a claim for benefits is not received in the Plan office or PPO Contracted Network within 365 days of the date the expenses are incurred.
- Expenses in excess of the Usual, Customary and Reasonable rate.
- Expenses in excess of the maximum benefits provided in Schedule of Dental Benefits.

# BENEFITS FOR ELIGIBLE DEPENDENT CHILDREN OF ACTIVE PARTICIPANTS AND PENSIONERS

The following benefits are available to eligible dependent children of participants (active participants and pensioners) as provided in Schedule W.

## **SCHOLARSHIP BENEFIT**

### **Benefit Types and Schedules**

- Scholarship Benefit (Schedule W)

### **Eligibility Requirements**

- Active participants must be eligible for medical benefits under the American Maritime Officers Medical Plan both on the date the scholastic year starts and ends. An active participant must be employed by a company whose contributions to the Medical Plan include funds for the scholarship benefit both on the date the scholastic year starts and ends.
- Pensioners must have retired from a company whose contributions to the Medical Plan included funds for the scholarship benefit and must have been eligible for Active benefits on the pension effective date and, if applicable, the date the pensioner declared retirement, and must be eligible for medical benefits under the American Maritime Officers Medical Plan both on the date the scholastic year starts and ends.
- Students must be registered and complete the scholastic year as a full time student.
- Students must meet the Plan's definition of an eligible Dependent child as defined on page [11](#) except that a Dependent child who turns age 23 during the scholastic year and has not previously received more than three (3) Scholarship benefits under the Plan will be considered eligible for that scholarship year.
- Scholastic year means consecutive semesters attended not to exceed one year. The term full-time student means the completion of 12 credit hours per semester or its equivalent during a scholastic year. Credits completed during summer or winter sessions may be applied to any one semester in a scholastic year.

### **Benefit**

- The AMO Medical Plan provides all eligible participants with yearly scholarship benefits as provided in Schedule W for each Dependent child maintaining a passing grade point average (2.0 in a 4.0 system, or the equivalent) as a full time student in an accredited college or trade school (four years of undergraduate study or the equivalent).
- Benefits are paid to the participant at the close of the scholastic year upon fulfillment of eligibility requirements as described above, provided the participant has furnished the Plan Office with an original scholarship benefit application, including affidavit of student support, and a transcript of grades indicating that the Dependent child has successfully completed a scholastic year's studies with a passing grade point average (2.0 or higher in a 4.0 system, or the equivalent).
- Benefits may be paid at the beginning of a school year (on a pre-paid basis) if the following conditions are met:
  - The participant and Dependent child sign a commitment to sail for a participating employer.
  - The Dependent child is attending a Maritime Academy.
  - Prior to issuance of a new year's Scholarship Benefit on a pre-paid basis, the school record for the past year must be submitted and reviewed by the Plan.
  - If these eligibility requirements do not continue to be met, the participant will forfeit all future rights to any scholarship benefit unless the prepaid scholarship is paid back within 6 months of failure to meet the eligibility requirements, such as dropping out of the academy. Once repayment is made, the regular benefit would be available provided the general eligibility requirements are met.

## BENEFITS FOR ACTIVE PARTICIPANTS ONLY

The following benefits are for active participants only and are not available to pensioners (unless they meet the requirements outlined below for active participant benefits), spouses or dependents.

### DEATH AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFITS

#### Benefit Types and Schedules

- Death Benefit (Schedule L1)
- Accidental Death and Dismemberment (Schedule M1)

#### Eligibility Requirements

- Death Benefit and Accidental Death and Dismemberment Benefit  
30 days of Covered Employment with one or more contributing employers within a period of six consecutive months, provided the last day of Covered Employment was not more than six months before death or dismemberment..

#### Exclusions and Limitations

- No Death or Accidental Death and Dismemberment Benefit is payable to Pensioners except In-Service Lump Sum recipients and return to work Pensioners who are eligible for active benefits on their date of death and meet the requirements above.
- No Accidental Death & Dismemberment Benefit is payable if the death or loss is a result of:
  - disease, bodily or mental infirmity, or medical or surgical treatment
  - ptomaine or bacterial infection, except infection introduced through a visible wound accidentally sustained.
  - suicide while sane or insane, or intentionally self-inflicted injury.
- Schedule of Indemnities for Accidental Death & Dismemberment and Supplemental Accidental Death & Dismemberment:

Full amount of benefit will be payable for loss of *:	One-half of the full amount of benefit will be payable for loss of *:
<ul style="list-style-type: none"> <li>• Life</li> <li>• Both hands</li> <li>• Both feet</li> <li>• One hand and one foot</li> <li>• Sight of both eyes</li> <li>• One hand and sight of one eye</li> <li>• One foot and sight of one eye</li> </ul>	<ul style="list-style-type: none"> <li>• One hand</li> <li>• One foot</li> <li>• Sight of one eye</li> </ul>

\* Loss of hands or feet means loss by severance at or above the wrist or ankle joint. Loss of sight means total and irrevocable loss of sight.

- If a participant suffers more than one of the losses described above as a result of any one accident, no more than the full amount of the benefit will be paid.

# BENEFITS FOR ACTIVE PARTICIPANTS ONLY (Continued)

## **SICKNESS AND ACCIDENT DISABILITY BENEFITS (MARITIME PARTICIPANTS ONLY)**

### **Benefit Types and Schedules**

- Disability Benefit (Schedule S)

### **Benefit Description**

- When disability, physical or mental, makes a participant unfit to perform his normal duties, and requires regular care and attendance of a legally qualified physician, the Plan provides a weekly benefit up to the maximum number of weeks established in Schedule S.

### **Requirements**

- The participant must submit to reasonable examinations as required by the Trustees to determine the disability.
- An Application for Sickness and Accident Disability Benefit form must be completed by both the participant and the attending physician for each claim during the disability period, and sent to the Plan office.
- Payments will be made no more frequently than at seven (7) day intervals.

### **Exclusions and Limitations**

- There is a waiting period for each disability of one (1) day after the date of an injury or eight (8) consecutive days from the date of illness. There will be no waiting period from the date of confinement in a hospital.
- No benefits or credit for a waiting period will be given for any period during which the participant is on the payroll of the Employer, including earned wages, vacation benefits, sick leave (if contributions are being made to the Plan), unearned wages (if contributions are being made to the Plan), or family leave (Great Lakes only and if contributions are being made to the Plan).
- The Plan will offset disability payments by Disability or Worker's Compensation under the laws of any state, maintenance and cure as required by Maritime law, unearned wages (if no contributions are made to the Plan), or sick leave (if no contributions are made to the Plan), or family leave (if no contributions are made to the Plan).
- Where a participant who is eligible for benefits under the AMO Medical Plan is disabled while working on a non-signatory vessel, no Disability Benefits shall be payable under the AMO Medical Plan.
- A participant who received a Disability Benefit under this Plan and who after returning to work is again determined to be disabled with a similar diagnosis within a period of 182 days from the last day of the previous disability, will be eligible for additional benefits not to exceed the maximum benefit provided in Schedule S for the total accumulated disability period.
- The term "legally qualified physician" for declaring a participant disabled shall mean only a person who is duly licensed to prescribe and administer any and all drugs.

# BENEFITS FOR DEEP SEA ACTIVE PARTICIPANTS ONLY

## WAGE INSURANCE (DEEP SEA ONLY)

If a covered participant is unable to collect his wages (which will be deemed to include all compensation due by reason of employment on a vessel, including Money Purchase Benefit contributions, but not any payment or penalty which is not provided under the collective bargaining agreement or 401(k) plan contributions) without recourse to legal, equitable or admiralty proceedings because his employer is insolvent, bankrupt or otherwise unable to pay the compensation due him, he will be entitled to payment from the Plan equal to the amount of his uncollected wages, less administration and collection expenses of 10%.

Application for Benefits must be made on forms provided by the Plan Office. 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 the facts from the employer. It is important to realize that the information required for payment is the same type of information that would be required by a Federal Court to substantiate the amount due.

Prior to payment, the covered participant will execute an assignment on 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 either in his name or their names or in the name of the Plan. The covered participant will also execute an authorization for the Plan to apply 10% of any payment for legal and administrative expenses incurred by the Plan in connection with the administration of the wage insurance program.

This benefit will provide a prompt payment to an eligible covered participant of the amount which 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. After completion of proof and execution of other documents, the Plan will pay to the participant 90% of the amount of compensation ascertained to be due. Except when procured by fraud or misrepresentation, this payment is final and not subject to any claim by the Plan. The remaining 10% will be held in escrow, and will be used to meet the administrative and legal costs of the program.

# BENEFITS FOR PENSIONERS AND THEIR DEPENDENTS

The American Maritime Officers (AMO) Medical Plan includes Hospital, Medical, Optical and Scholarship Benefits for certain pensioners with 20 or more years of pension credit and their eligible dependents (unless otherwise specified below). One of the requirements is that at the effective date of the American Maritime Officers (AMO) Pension Plan benefit, the pensioner must be eligible for coverage as an active participant under the AMO Medical Plan. Pensioner medical benefits are dependent on both the level of benefits in effect at the time the AMO Pension Benefit is effective and the number of years of pension credit, unless the Trustees specifically provide otherwise. The Trustees reserve the right to amend, modify or terminate, in whole or in part, pensioner medical benefits.

Medical benefits for Pensioners are subject to annual earnings limitation requirements. Pensioners and/or eligible dependents are required to submit to the Plan (annually) a completed Pensioner's Medical Benefits Earnings Limitations and Coordination of Benefits form as well as a copy of their latest completed and signed annual tax return as filed with the IRS. For the initial period of gainful employment in a calendar year, submission of the Pensioner's or dependent's pay slips or pay stubs indicating when the earnings limitation is met will be required. In the event that Pensioner or dependent earnings exceed the annual limitations established by the Plan's Rules & Regulations, medical benefits will cease as of the date in said calendar year that the annual earnings limitation is met. In the event that medical benefit payments are made during the calendar year in which the earnings exceed the annual limitations, such payment will be reimbursed to the Plan by the Pensioner or Pensioner's eligible dependent, or by deductions from future medical benefits.

## COVERAGES

<u>AREA</u>	<u>PENSION CREDITS</u>	<u>COVERAGE <sup>(1)</sup></u>
Deep Sea/Great Lakes/Inland Waters	20 or more years	Pensioner Benefits <sup>(2)</sup>
Deep Sea/Great Lakes/Inland Waters	Under 20 years	None
Deep Sea/Great Lakes/Inland Waters	Under 20 years (Disability)	Similar to Medicare <sup>(3)</sup>

- <sup>(1)</sup> Pensioners and/or their dependents can extend the medical coverage they received as an active participant under the AMO Medical Plan by applying for COBRA coverage. This coverage will be for the duration outlined under the COBRA provisions.
- <sup>(2)</sup> Pensioner Benefits are Hospital, Medical, Optical and Scholarship Benefits, as provided for on the effective date of the AMO Pension benefit, unless amended, modified or terminated, or unless the Trustees specifically provide otherwise. Dental benefits will terminate on the Pension Effective Date.
- <sup>(3)</sup> For pensioners with pension effective dates on or after January 1, 1995, and less than 20 years of pension credit, there will be no medical coverage unless the participant retired with an AMO Disability Pension Benefit. Those pensioners retiring with an AMO Disability Pension Benefit will have "Similar to Medicare" coverage under the AMO Medical Plan. Similar to Medicare Benefits are Hospital and Medical Benefits as outlined on the applicable schedule (see page 68). Prescription drug benefits are excluded under Similar to Medicare (STM) coverage. The dependents of a disabled pensioner, and the pensioner, may extend the medical coverage received as an active participant by applying for COBRA coverage. This coverage will be for the duration as outlined under the COBRA provisions. STM coverage will cease on the date Medicare becomes effective.

## MEDICAL AND HOSPITAL BENEFITS

Pensioners and their dependents with Pensioner Benefits are entitled to the medical and hospital benefits that were in effect on the effective date of the pensioner's AMO Pension benefit, subject to the Rules and Regulations of the Medical Plan, unless amended, modified or terminated, or unless the Trustees specifically provide otherwise. Please refer to the applicable group's Schedule of Benefits. Annual Co-Insurance maximums are not applicable as of Pension Effective Date.

## LIFE BENEFIT

For pensioners covered under the AMO Pension Plan's 60-month guarantee pension payout, a \$500 Life Benefit is payable if the 60 months of guaranteed payments under the AMO Pension Plan were satisfied prior to the pensioner's death.

### **OPTICAL BENEFIT**

Pensioners and their dependents with Pensioner Benefits are eligible for the optical benefit as in effect on the effective date of the pensioner's AMO Pension benefit, unless amended, modified or terminated, or unless the Trustees specifically provide otherwise.

### **SCHOLARSHIP BENEFIT**

Eligible dependent children of pensioners receiving Pensioner Benefits under the AMO Medical Plan are entitled to scholarship benefits currently in effect regardless of the effective date of the pensioner's AMO Pension benefit, unless amended, modified or terminated, or unless the Trustees specifically provide otherwise.

### **SURVIVOR BENEFIT**

In the event a pensioner receiving Pensioner Benefits predeceases his spouse, the surviving spouse and eligible dependent children continue to qualify for medical benefits, provided the surviving spouse is receiving a Survivor's Pension Benefit under the AMO Pension Plan, or benefits were paid under the Lump Sum Option. If the 60-month payout is in effect, the surviving spouse and eligible dependents will be entitled to medical coverage only for the remaining period of such 60-month payout. The Trustees reserve the right to amend, modify or terminate, in whole or in part, survivor benefits.

### **EXCLUSIONS AND LIMITATIONS**

- The AMO Medical Plan does not provide medical benefits to any pensioner and/or any pensioner's dependent who has earnings from gainful employment that are in excess of the amount permitted under the Rules and Regulations of the AMO Medical Plan.
  - Deep Sea/Great Lakes/Inland Waters - Calendar year earnings from gainful employment cannot exceed twice the maximum amount permitted by Social Security.
  - Inland Waters (Group IA only) - Calendar year earnings from gainful employment cannot exceed the maximum amount permitted by Social Security.
- Pensioner and pensioner's dependents do not have hearing aid coverage.
- Pensioner and pensioner's dependents do not have dental coverage.
- Upon being eligible for benefits under the Federal Medicare Program, Similar to Medicare benefits under the AMO Medical Plan will terminate.
- For those pensioners or pensioner's dependents eligible for Pensioner Benefits (Deep Sea/Great Lakes/Inland Waters) and also eligible for coverage under the Federal Medicare Program or its related affiliates, the Plan will supplement Medicare benefits up to the Medicare allowable rate and subject to Plan limitations and exclusions.
- In the event a Medicare Eligible Pensioner enrolls in any Medicare Part D prescription drug plan or any other qualified Medicare prescription drug plan in any year, prescription drug coverage under the Plan will terminate for that year. Subsequently, on an annual basis, should the Medicare Eligible Pensioner terminate enrollment in any Medicare Part D prescription drug plan or any other qualified Medicare prescription drug plan, he/she will be permitted to reinstate his/her prescription drug coverage under the Plan.
- No benefits are payable to any pensioner, or his dependent, who retires from a company that does not participate in the AMO Medical Plan.

### **PENSIONERS RETURNING TO WORK**

- A pensioner who returns to employment aboard a vessel, including a return to Covered Employment, without written permission from the Trustees of the AMO Pension Plan, will forfeit all eligibility for benefits under the AMO Medical Plan, unless he subsequently re-retires from employment with a company signatory to the AMO Medical Plan.

# PRE-CERTIFICATION

## PRE-CERTIFICATION PROCESS

The AMO Medical Plan requires that certain services be pre-certified by the Plan or CIGNA – CareAllies. This pre-certification process enables the Plan to monitor the medical necessity of services being performed, as well as contain costs. **Pre-certification does not guarantee benefit payment.**

## OUTPATIENT PRE-CERTIFICATION PROCESS

In order to obtain outpatient pre-certification, the participant or the participant's physician should call the AMO Medical Plan at (800) 348-6515.

### AMO must pre-certify prior to the event

- Outpatient Surgical Procedures
- Outpatient hospital services subject to an incident co-payment
- Chemotherapy
- Durable Medical Equipment (rental or purchase)
- Home Health Care
- Therapeutic Services (physical, occupational, speech, cardiac rehabilitation)
- Fertility Treatments (including prescription drugs, procedures and all related medical services)
- Specialty drug treatment programs

In order to verify eligibility and benefits, the participant or participant's physician should call the AMO Medical Plan at (800) 348-6515.

## INPATIENT PRE-CERTIFICATION PROCESS

The CIGNA program will include an Inpatient Hospital Medical and Surgical Pre-Admission Certification Program. All inpatient admissions and inpatient surgery will need to be pre-certified starting January 1, 2008 with CIGNA – CareAllies at (800) 768-4695.

### CIGNA – CareAllies - Must be pre-certified prior to the event

- Inpatient non-emergency hospital admissions
- Inpatient and outpatient non-emergency surgery
- Inpatient Rehabilitation

### CIGNA – CareAllies must pre-certify within 2 business days

- Emergency hospital admissions
- Inpatient emergency surgery

## AMO CASE MANAGEMENT

Case Management is an AMO Medical Plan team consisting of professionals, including a Medical Doctor (MD), Registered Nurse (RN), Advanced Registered Nurse Practitioner (ARNP) and Coordinator, that provides the following services. . The AMO Plan's Case Management Team will provide participants with guidance and assistance with all Medical Plan benefits.

- Direct care to appropriate providers
- Provide educational resources
- Authorize and arrange Home Health
- Authorize and arrange for special equipment
- Authorize and manage specialty drug treatments
- Authorize and manage all fertility benefits
- Utilization review of medical records
- Negotiations with out-of-network providers
- Arrange for medical services with providers
- Advocate for AMO Medical Plan participants

## PRE-CERTIFICATION (Continued)

### **CIGNA - CareAllies CASE MANAGEMENT**

The CIGNA program includes a specified Inpatient Case Management Program. If the patient meets certain chronically or critical medical criteria (i.e.: cancer, serious spinal cord injury, diabetes, heart disease, etc.) a CareAllies Case Manager will provide the patient with the information for enrollment into the CIGNA Case Management Program and will be coordinated with the AMO Medical Plan's Medical Resource Team.

**IN SUMMARY: INPATIENT HOSPITALIZATION AND INPATIENT SURGERY PRE-CERTIFICATION WILL BE THROUGH CIGNA AND ALL OTHER REQUIRED PRE-CERTIFICATION OF MEDICAL SERVICES (SEE ABOVE) WILL BE THROUGH THE AMO MEDICAL PLAN.**

### **FAILURE TO PRE-CERTIFY**

Failure to pre-certify and obtain approval for the above services may result in a reduction in benefits of up to \$250 of the otherwise eligible benefit per occurrence. Any penalty incurred will not be applied to the deductible or the annual co-insurance maximum.

### **VERIFICATION OF ELIGIBILITY & BENEFITS**

As part of the pre-certification process, the AMO Medical Plan Office will verify eligibility and benefits. The participant or the participant's physician should *always* call the Plan Office at (800) 348-6515 to verify continued eligibility and benefits immediately prior to the procedure.

## COORDINATION OF BENEFITS

There are cases where a participant or dependent may be covered or eligible for benefits under another Plan. For such situations, benefits must be coordinated. The chart on page 39 entitled "Order of Determination" details the provisions used by the Plan to coordinate benefits.

### DEFINITION OF 'PLAN'

Examples of plans considered under the coordination of benefits provision are:

- group, blanket or franchise insurance coverage;
- motor vehicle insurance;
- group health plans;
- any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- any coverage under governmental programs including the Federal Medicare Program or CHAMPUS.

### DEPENDENT SPOUSE – EMPLOYED FULL TIME

The Rules and Regulations of the AMO Medical Plan regarding Coordination of Benefits for a dependent spouse require that the Plan consider group medical coverage offered through a spouse's full-time employment first and the AMO Medical Plan will be secondary. **Full-time employment means 30 hours or more per work week.**

***IMPORTANT -- If a spouse working full-time rejects group medical coverage, even if coverage is at a cost to the spouse, the AMO Medical Plan will only pay claims at twenty percent (20%) of the otherwise eligible benefit.***

As secondary payer, the AMO Medical Plan will reimburse medical expenses that were not paid by the primary carrier up to the maximum benefit payable under the Plan (after application of applicable deductibles and co-payments).

Legible copies of itemized bills for all expenses being claimed should be submitted along with any payment or rejection notices (Explanation of Benefits) from the primary carrier.

If a spouse's employer offers different medical benefit coverage options, a comprehensive policy including hospital, surgical, medical, prescription drugs, etc. must be selected. If optical coverage and/or dental is offered, these must be elected as well. The AMO Medical Plan may request a copy of the Summary Plan Description of the other plan. If a spouse's employer participates in an HMO, PPO, or other managed care plan, the spouse must follow the rules of that plan. If the spouse has services rendered by a non-participating provider, the AMO Medical Plan will only pay claims at twenty percent (20%) of the otherwise eligible benefit.

### DEPENDENT CHILD

If a dependent child is covered at no cost through a group plan by virtue of the spouse's full-time employment or if the spouse elects "family" coverage, benefits for the dependent child will be coordinated in accordance with the Order of Determination chart on page 39. ***Please note that a spouse who is employed full time is not required to take "family" coverage unless it is without cost. If a dependent child has independent coverage of his or her own, that plan will be primary.***

### AUTOMOBILE INSURANCE

The AMO Medical Plan will not pay any benefits relating to an automobile accident until all benefits payable under any automobile insurance policies have been paid and exhausted. The AMO Medical Plan will be secondary even if you choose an automobile insurance policy that provides that any group policy will be primary. Wage payments cannot be taken in lieu of medical benefits, and if wage payments are taken, they will be offset against any medical benefits payable under the AMO Medical Plan.

## COORDINATION OF BENEFITS (Continued)

### ORDER OF DETERMINATION

	SITUATION	PRIMARY	SECONDARY	TERTIARY
A	Participant or dependent covered under automobile insurance policies	All automobile insurance policies	AMO Medical Plan	N/A
B	Participant's dependent is covered under own Plan	Dependent's group plan <sup>1</sup>	AMO Medical Plan	N/A
C	Parents are married	Birthday Rule (parent whose birth date falls earlier in the calendar year or if same birthday, parent who has had coverage longest)	Other parent's medical plan	N/A
D	Parents are married, but spouse's health coverage does not recognize birthday rule	Father's medical plan	Mother's medical plan	N/A
E	Parents are divorced, separated or never married, and court decree establishes financial responsibility for health expenses (including QMCSO)	Parent given responsibility by the court <sup>2</sup>	Apply rules F and G	N/A
F	Parents are divorced or separated	Parent with custody	Parent without custody	N/A
G	Parents are divorced, but parent with custody re-marries	Natural parent with custody	Stepparent that has child as dependent	Natural parent without custody
H	Parents never married	Parent who is primary custodial care giver	Other natural parent	N/A
I	Parents never married, but parent who is primary custodial care giver remarries	Parent who is primary custodial care giver	Stepparent that has child as dependent	Natural parent without custody
J	Rules A–I do not establish primary coverage	Plan that covered claimant for longest period	N/A	N/A

<sup>1</sup> If group medical coverage is rejected by a spouse employed full-time, the AMO Medical Plan will only pay claims at twenty percent (20%) of the otherwise eligible benefit.

<sup>2</sup> If the parent with financial responsibility fails to provide court ordered health insurance, the AMO Medical Plan, as secondary payer, will only pay medical benefits at 20% of the otherwise eligible benefit.

# CLAIM DOCUMENTATION

The following is information regarding the documentation required to submit in-network, out-of-network and other claims (optical, prescription drug, direct reimbursement dental benefit, hearing aid, disability benefits, wage insurance, death benefits or accidental death and dismemberment benefits).

## **PPO CLAIM SUBMISSION**

Claim submission for any of the PPO's with which the AMO Medical Plan is contracted is a very simple process. When utilizing a PPO provider, there is less paperwork and easier accountability. The following steps should be taken to insure accurate claim submission:

- Plan participants should present their AMO Medical Plan PPO identification card to the provider of service (physician, lab, hospital, therapist, etc.) at the time of service. You may be asked to pay any applicable co-payments, deductibles or co-insurance at this time. The AMO Medical Plan PPO identification card contains specific benefit and billing information for the provider.
- The PPO provider will send the bill directly to the applicable PPO or the AMO Medical Plan for repricing. If a participant receives a bill for services performed at a PPO facility or by a PPO provider, the original bill should be sent to the applicable PPO as indicated on your identification card promptly for processing. The PPO will handle the claim and the participant will receive an Explanation of Benefits once a determination is made.
- Please be aware that all bills must be received by the Plan office within 365 days from the date of service or benefits will not be payable.

## **NON-PPO CLAIM SUBMISSION**

When a Plan participant uses a provider who is not part of one of the PPO's with which the Plan is affiliated, the following procedures must be followed to submit claims for benefit reimbursement:

- The claim must include original itemized bills from each provider of service and be submitted to CIGNA or as otherwise indicated on your identification card.
- To insure correct benefit payment, each claim submitted to the Plan office should be accompanied by a completed AMO Medical Plan Application for Benefits form. This form provides the Plan with important information so that the claim can be paid accurately and to the proper party.
- If a non-PPO provider sends a bill directly to CIGNA or the AMO Medical Plan without a completed Application for Benefits, the claim will be processed and the applicable benefit will be paid directly to the provider of service, provided an assignment of benefits is indicated on the bill (the Plan may request the participant complete an Application for Benefits, if necessary). The Plan participant will receive an Explanation of Benefits indicating the Plan's determination.
- In the event a non-PPO provider sends a bill directly to CIGNA or the AMO Medical Plan without a completed Application for Benefits or an assignment of benefits, any applicable benefit will be paid directly to the Plan participant. Should this occur, it is the participant's responsibility to reimburse the provider of service.

## **GENERAL REQUIREMENTS FOR ALL CLAIM SUBMISSIONS**

CIGNA and/or the AMO Medical Plan accept bills from many types of providers of service as stipulated in the Rules and Regulations. To guarantee that claims are processed expeditiously and accurately, separate itemized bills on appropriate billing forms (i.e., HCFA 1500s, superbills) must be submitted to CIGNA, any other PPO with which the Medical Plan or CIGNA is contracted, or the Plan Office and must contain the following information:

- Provider of service's full name,
- Professional title (e.g., MD, DO, DDS, DMD, DPM, etc.),
- Tax identification number (TIN),
- Patient's full name,
- Plan participant's full name and social security number,
- Procedure performed, service rendered, or item supplied (CPT, ADA, HCPCS codes),
- Diagnosis (ICD code),
- Date of service, and
- Amount charged for each service rendered or item supplied.

## **ADDITIONAL REQUIREMENTS FOR SPECIFIC BENEFIT CLAIM SUBMISSIONS**

### **Hospital Expenses**

- All hospital bills must be sent on form UB94, which is the standard hospital billing form. The UB94 contains pertinent information in order for the AMO Medical Plan to process hospital claims.
- An Application for Benefits does not need to accompany a UB94 unless the participant has paid the bill and expects direct reimbursement.

# CLAIM DOCUMENTATION

## (Continued)

### Home Health Care And Durable Medical Equipment

- The AMO Medical Plan requires a physician's (MD or DO) authorization for home health care visits or durable medical equipment (rental or purchase). The physician's authorization must include the frequency and duration. Pre-certification of medical necessity by the Plan or its representative must be granted prior to obtaining home health care or durable medical equipment.

### Therapeutic Treatment

- A physician's (MD or DO) statement must be submitted to the Plan outlining the treatment plan. The statement must include the diagnosis, prognosis, frequency and duration of therapy.

### Optical

- An itemized bill must be submitted to the Plan specifying the services rendered.

### Dental (Direct Reimbursement)

- An itemized bill must be submitted to the Plan specifying the dental services rendered and reflecting that all services have been paid in full. **BENEFITS WILL NOT BE PAID DIRECTLY TO THE DENTIST OR DENTAL SERVICE PROVIDER.**

### Prescription Drug Claim Submission

Prescription drugs should be obtained through a participating network pharmacy. However, if an eligible drug is purchased at a non-participating facility, the following procedures should be followed for claim reimbursement:

- Complete a Prescription Drug Claim Form (available at the AMO Medical Plan office)
- Attach the pharmacy bill including:
  - Pharmacy name and address,
  - Prescription number (Rx number),
  - National Drug Code (NDC),
  - Drug name.
- Send the claim to the prescription drug administrator's address listed on the prescription drug claim form. Reimbursement will be sent directly to the Plan participant by the Pharmacy Benefit Manager.

### Claim Submission With Coordination Of Benefits

- If the AMO Medical Plan is not primary, the Plan requires legible copies of itemized bills for all submitted expenses, along with an Explanation of Benefits showing payment or denial by the primary insurer.
- A completed AMO Medical Plan Application for Benefits must be submitted for each claimant.

*Cash register receipts, canceled checks, money order receipts, statements of account and personal itemizations are NOT ACCEPTABLE as itemized bills.*

All bills must be received by the Plan office within 365 days from the date of service or benefits will not be payable.

# MEDICAL CLAIM SUBMISSION

The following sets forth the procedure for filing claims for benefits under the AMO Medical Plan, and the procedure for you to follow if your claim for benefits is denied in whole or in part, or if any adverse determination is made with respect to your claim and you wish to appeal the decision.

## **TIME FOR FILING CLAIMS**

Claims for benefits under the AMO Medical Plan must be filed within 365 days following the date the charges are incurred. No plan benefits will be paid for any claim not submitted within this period. Claim forms are available from the AMO Medical Plan office and at various Union offices. (See page [10](#) for a list of offices).

Generally, inquiries considering the Plan's provisions that are unrelated to any specific benefit claim or are exclusively about eligibility will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. Benefits received from in-network providers and presentation of a prescription to a pharmacy that exercises no discretion on behalf of the Plan also are not considered a claim under these procedures. However, if your request for any of these benefits is denied, in whole or in part, you may file a claim and appeal regarding the denial.

## **WHERE TO FILE YOUR CLAIM**

You will not be required to submit a claim form for hospital, medical or prescription drug benefits if you use a provider in one of the Plan's PPO networks, or the Pharmacy Benefit Manager's (PBM) participating pharmacy. In such cases, the provider will submit a claim directly to the applicable PPO or AMO Medical Plan. If you do not use an in-network medical provider, the provider (or you, if the provider does not do so) should submit a claim to CIGNA or as otherwise indicated on your identification card. If your claim is for optical, dental, hearing aid, disability benefits, wage insurance, or death benefits or accidental death and dismemberment benefits, you will be required to submit a claim form, together with supporting documentation, to the Plan.

## **Hospital and Medical Claims**

If you use a hospital, doctor, or other type of medical facility that belongs to one of the Plan's PPOs, you generally are not required to file a claim for benefits because the provider will submit the claim directly to the PPO or the Plan. If you use the services of a hospital, doctor, or other medical facility that does not belong to a PPO, the provider (or you, if the provider fails to do so) should submit the claim directly to CIGNA or as otherwise indicated on your identification card, together with an original itemized bill.

## **Optical Claims**

A claim form, together with an original itemized bill and supporting documentation specifying the services rendered, must be submitted to the Plan.

## **Dental (Direct Reimbursement) Claims**

An itemized bills must be submitted to the Plan specifying the dental services rendered and reflecting that all services have been paid in full. **BENEFITS WILL NOT BE PAID DIRECTLY TO THE DENTIST OR DENTAL SERVICE PROVIDER.**

## **Prescription Drug Claims**

You do not need claim forms when utilizing a participating pharmacy. Simply present your card and your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled under the terms of the Plan that is not considered a claim under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim with the Plan under these procedures. If you do not use a participating pharmacy, a prescription drug claim form, together with the pharmacy bill, must be submitted to the Pharmacy Benefit Manager.

## **Other Benefits**

A claim for other benefits under the AMO Medical Plan, including optical, direct reimbursement dental benefits, disability benefits, death benefits, AD&D benefits, scholarship benefits, and wage insurance benefits must be submitted to the Plan.

# MEDICAL CLAIM SUBMISSION (Continued)

## **CLAIMS PROCEDURE**

A claim for benefits will be considered to have been filed when it is received by the appropriate entity responsible for making the initial benefit determination as described above.

### **Pre-Service Claim (Pre-Certification)**

A Pre-Service Claim is a claim for medical benefits for which the Plan requires approval prior to medical care being obtained, such as non-emergency surgery or hospitalization. If you fail to pre-certify these services, your benefits may be reduced. (See page 36 for pre-certification requirements). Pre-Service claims for inpatient hospitalization and inpatient surgery should be submitted to CIGNA - CareAllies. Any other pre-service claims should be submitted to the Plan office. If you submit a Pre-Service Claim, you will generally be notified of the Plan's determination within 15 days after receipt of the claim, unless additional time is needed. The time for making a determination may be extended up to 15 days if necessary due to matters beyond the control of the Plan and you are notified of the circumstances requiring the extension of time and the date by which a decision is expected to be made. If additional time is needed because CIGNA - CareAllies or the Plan has not been provided with the information necessary to make a decision, you will be notified and provided 45 days from receipt of the notification to supply the additional information. In that case, the time for making a decision on your claim will be suspended until CIGNA - CareAllies or the Plan receives the additional information. CIGNA - CareAllies or the Plan will then have 15 days to make a decision and notify you of its determination. If you improperly file a Pre-Service Claim, you will be notified no later than 5 days after receipt of the claim of the proper procedures, provided the claim includes your name, the specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

### **Urgent Care Claim**

Urgent Care is any pre-service claim for medical or prescription care or treatment that, if not decided quickly, could seriously jeopardize your life or health or your ability to regain maximum function, or that, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

If your claim involves urgent care, you will be notified of a decision as soon as possible, but no later than 72 hours after receipt of the claim. Notification may be given orally and will be confirmed in writing. If you do not provide the Plan with sufficient information to make a decision on coverage, you will be advised as soon as possible, but no later than 24 hours after receipt of your claim. You will then have 48 hours to provide the specified information necessary to complete the claim. The Plan will then notify you of its determination within 48 hours after the earlier of receipt of the specified information, or the end of the 48 hours afforded to you to provide the additional information. If you improperly file a claim for urgent care, you will be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the proper procedure to be followed, provided the claim includes your name, the specific medical condition or symptom, and a specific treatment, service or product for which approval is requested. This notification may be oral unless written notification is requested. Unless the claim is refiled properly, it will not be considered a claim

If your claim involves urgent care and is a request to extend a course of treatment beyond the initially approved period, or number of treatments, you will be notified of a determination within 72 hours after receipt of the claim, unless a claim is submitted at least 24 hours prior to the date the approved period is to end, in which case a decision on your claim will be made within 24 hours of receipt of the claim. Claims involving inpatient hospitalization and inpatient surgery should be submitted to CIGNA - CareAllies.

### **Concurrent Claim**

A Concurrent Claim is a claim for medical benefits that is reconsidered after an initial approval was made and that results in a reduction, termination, or extension of a benefit. If you are receiving concurrent care benefits, such as where a certain number of days of hospitalization or treatment has been approved, and the Plan or CIGNA - CareAllies decides to reduce or terminate the course of treatment before the end of the previously approved treatment period (other than by Plan amendment or termination), you will be notified of the adverse determination sufficiently in advance of the reduction or termination of benefits to allow you ample time to appeal the decision and obtain a determination before the benefit is reduced or terminated. If you submit a claim to extend a course of treatment beyond the approved period of time or number of treatments, your claim will be treated as a Pre-Service or Post-Service Claim depending on the nature of the claim, unless it involves Urgent Care.

# MEDICAL CLAIM SUBMISSION

## (Continued)

### Post-Service Claim

Most claims under the Plan will be Post-Service Claims. A Post-Service Claim is a claim for medical or prescription drug benefits submitted for payment after services and treatment has been provided. It includes emergency hospitalization, which does not require pre-certification, but about which you must notify the Plan and CIGNA – CareAllies within two days of your admission. There are no claim forms to submit for in-network providers, and for most prescription drug benefits. These providers will submit claims directly. Receipt of such benefits from these providers does not constitute a claim under these procedures.

If a non-network provider or you need to submit a claim, ordinarily you will be notified of a decision on a Post-Service Claim within 30 days of receipt of the claim. This period may be extended for up to 15 days if necessary due to matters beyond the control of CIGNA – CareAllies or the Plan. If an extension is necessary you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which a decision is expected to be made. If you have not provided CIGNA – CareAllies or the Plan with sufficient information to make a decision, you will be advised and will have 45 days from receipt of the notification to supply the additional information. The normal period for making a determination will be suspended until you respond to the request for additional information. CIGNA – CareAllies or the Plan will then have 15 days to make a decision and notify you of its determination.

### Disability Benefits Claim

If your claim is for disability benefits under the Plan, a decision will generally be made within 45 days of receipt of the claim. If the Plan requires an extension of time due to matters beyond the control of the Plan, you will be notified before the expiration of the 45 days of the reason for the delay and when the decision will be made. A decision will be made within 30 days of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional 30 days provided you are notified prior to expiration of the first 30-day extension of the circumstances requiring the extension and the date by which the Plan expects to make a decision. If you have not provided the Plan with sufficient information to make a decision, you will be advised of the information needed and will have 45 days from receipt of the notification to supply the additional information. The normal period for making a determination will be suspended until you provide the requested information or the 45 days has passed. If the information is not provided within the 45 days, your claim will be denied. If the information is provided, you will be notified of the Plan's decision within 30 days of receipt of the information.

### Other Benefit Claims

If your claim is for optical benefits, direct reimbursement dental benefits, death benefits, accidental death and dismemberment benefits, scholarship benefits, or wage insurance benefits, a decision will be made within 90 days of receipt of your claim. If additional time is required, you will be notified of the reason for the delay and when the decision will be made. A decision will then be made within 90 days of the notification. If an extension is required because additional information is needed from you, you will be advised of the information needed and the normal period for making a decision will be suspended until this information is received.

### NOTICE OF DECISION

If you file a claim for benefits and your claim is denied, in whole or in part, you will be notified in writing. The notice will contain the following information:

- The specific reasons for the adverse determination;
- The specific provisions of the Rules and Regulations or procedures on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) upon an adverse determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy or a statement that it is available upon request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, or a statement that it is available upon request at no charge;
- If the claim involves an Urgent Care, a description of the expedited review procedure applicable to Urgent Care Claims.
- For all Pre-Service Claims, including Urgent Care Claims, you will be advised if the claim is granted or denied. If you do not receive a determination, or notice of extension, within the timeframes provided above, your claim will be deemed denied.

# MEDICAL CLAIM SUBMISSION (Continued)

## APPEAL PROCEDURE

### Appeal of Denied Claim (Other than Inpatient Hospital and Surgical Services)

With the exception of inpatient hospital and inpatient surgical services, if your claim for benefits is denied in whole or in part, you have the right to file an appeal for review by the Trustees. A request for review of a medical, prescription drug, or disability benefit claim must be submitted within 180 days following receipt of the denial of the claim. A request for review of any other benefit claim must be submitted within 60 days of receipt of the denial. Appeals involving Pre-Service and Urgent Care Claims may be made orally by calling 1-800-348-6515 or 1-954-920-4247. All other requests must be in writing and submitted to the AMO Medical Plan.

You, or your authorized representative, have the right to review, free of charge, all documents, records or other information relevant to your claim, and may submit written comments, documents, records and other information relating to your claim. You also have the right to appear in person before the Trustees (or Subcommittee). Upon request, you will be provided with the identification of medical or vocational experts, if any, whose advice was obtained by the Plan (even if not relied upon).

Your appeal will be submitted by the Plan Office to the Trustees. The Chairman and Secretary may in their discretion appoint a Subcommittee of two Trustees who shall be delegated to hear and determine the appeal. In the case of an appeal involving Urgent Care, any two Trustees are authorized to decide the appeal. The appeal will not defer to the initial benefit determination and will consider all comments, documents, records and other information submitted by you without regard to whether such information was submitted or considered in the initial determination. If your claim was denied on the basis of a medical judgment, such as whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, a health care professional (who was not consulted in the initial determination and not the subordinate of any health care professional who was consulted) who has appropriate training and experience in the relevant field of medicine will be consulted. The Trustees (or Subcommittee) hearing the appeal will consider the evidence presented and will listen to arguments for a reasonable period of time on behalf of the appeal.

### Appeal of Inpatient Hospital and Surgical Services

If your request for pre-certification of, or any other claim relating to, inpatient hospital and/or surgical services, is denied, in whole or in part, you have a right to file an appeal with CIGNA – CareAllies within 180 days of the denial. An expedited appeal is available when a delay might jeopardize the patient's life, health, or ability to regain maximum functionality or when requested due to failure to authorize a continuing inpatient hospital stay. CIGNA – CareAllies provides three levels of appeal. Appeals to CIGNA – CareAllies should be submitted to P.O. Box 5909, Scranton, PA 18505. A request for an expedited appeal may be made by calling (800) 768-4695.

### Expedited Appeal (offered at level 1&2)

**Expedited Case:** an expedited level one and/or level two medical necessity appeal is available when a delay might jeopardize life, health, or ability to regain maximum functionality of the member or when requested due to failure to authorize a continuing inpatient hospital stay.

- An attending physician, ordering provider, facility rendering service, and/or the patient/claimant can request an Expedited Appeal.
- CareAllies Medical Director explains expedited appeal process upon initial review denial.
- CareAllies Medical Director of appropriate expertise who was not involved in the original decision/review coordinates discussion with the treating provider. The review is completed within 72 hours; treating provider is verbally notified of the review decision.
- Notification letters are generated to all parties.\*

### First Level Appeal

- Request for appeal is received and forwarded to Appeals Coordinator within 1 calendar day.
- Receipt notification letter sent within 2 calendar days to the requesting party, communicating that information received and the expected review completion timeframe.
- Additional information may be requested from the treating provider. Extension notification letter is generated informing participant of 15 day extension time to complete request.

- Case reviewed by CareAllies Medical Director of an appropriate expertise, but not involved in the initial non-certification recommendation.
- Review completed within 15 calendar days for Prospective reviews and 30 calendar days for Retrospective reviews. (45 days if extension requested).
  - Medical Director overturns original non-certification. Notification letters are generated to all parties.\*
  - Medical Director upholds original non-certification. Denial notification letters sent to all parties explaining appeal decision and outlining the next level appeal option.\*

### Second Level Appeal

- Request for appeal received and forwarded to Appeals Coordinator within 1 calendar day.
- Receipt notification letter sent within 2 calendar days to the requesting party, communicating that information received and the expected review completion timeframe.
- Additional information may be requested from the treating provider. Extension notification letter is generated informing participant of 15 day extension time to complete request.
- Review completed within 15 calendar days for Prospective reviews and 30 calendar days for Retrospective reviews. (45 days if extension requested).
  - Medical Director overturns original non-certification. Notification letters are generated to all parties.\*
  - Medical Director upholds original non-certification. Denial notification letters sent to all parties explaining appeal decision and outlining the next level appeal option.\*

### Third Level/External Review Appeal

- Request for appeal received and forwarded to Appeals Coordinator within 1 calendar day.
- Case is assigned to External Review Agency.
- Receipt notification letter sent within 2 calendar days to the requesting party, communicating that information received and the expected review completion timeframe as appropriate.
- Review completed within 15 calendar days for Prospective reviews and 30 calendar days for Retrospective reviews.
- External entity overturns non-certification. Notification letters generated to all parties.\*
- External entity upholds non-certification recommendation. Notification letters sent to all parties explaining the appeal decision. For third level appeals CareAllies requests that any further appeals be sent to the Plan Administrator or the State Department of Insurance. \*

**\*Appeal Letters** are generated within 24 hours of the decision.

### Decision on Appeal

You will be notified of a decision on appeal of an Urgent Care Claim within 72 hours of receipt of the appeal. You will be notified of a decision involving a Pre-Service Claim within 30 days of receipt of the appeal, and within 60 days of receipt of an appeal of a Post Service Claim (30-45 days in the case of an appeal to CIGNA – CareAllies depending on the level of appeal and if an extension of time is requested). In the case of a claim for disability benefits, a decision will be made within 45 days of receipt of the appeal, which may be extended, with notification to you, for an additional 45 days if special circumstances require. An appeal involving any other benefits under the Plan will be decided within 60 days of receipt of the appeal, which may be extended, upon notification to you, for an additional 60 days if special circumstances require.

The decision of the CIGNA – CareAllies or the Trustees (or Subcommittee) on appeal will be given to you in writing and will be final and binding on all parties. The notice shall include:

- The specific reasons for the determination;
- Reference to the specific provisions of the Rules and Regulations or procedures on which the determination is based;
- A statement that you are entitled to receive upon request, without charge, reasonable access to and copies of all documents, records and other information relevant to your claim;
- A statement describing any voluntary appeal procedures and your right to obtain information about such procedures, and a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of

that rule or a statement that it is available upon request at no charge;

- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

#### **Limitation of when a Lawsuit may be Started**

You may not start a lawsuit to obtain benefits until after you have appealed and a final decision has been reached on your appeal, or until the appropriate time, as described above, has elapsed since you filed an appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. No lawsuit may be started more than 1 year after a final decision has been reached or the time for making a final decision has elapsed.

#### **Authorized Representative**

You may authorize on a form provided by the Medical Plan office someone else, such as your spouse, to act on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Plan may request additional information to verify that the person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim without your completing the special authorization form. If you have authorized a representative to act on your behalf, the Plan will direct all information and notifications to your representative unless you direct otherwise. Authorization forms are available at the Plan Office and various AMO offices.

#### **Contact Information**

If you have any questions, you should contact the AMO Medical Plan at 1-800-348-6515 or CIGNA – CareAllies at 800-768-4695. Claim forms, where necessary, should be submitted to the AMO Medical Plan, P.O. Box 35, Dania Beach, Florida 33004 or to the PPO at the address indicated on the identification card.

# MISCELLANEOUS INFORMATION

## **STATEMENT OF ERISA RIGHTS**

As a participant in the American Maritime Officers Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

### **Receive Information About Your Plan & Benefits**

Examine, without charge, at the Director of Benefits' office and at other specified locations, such as union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Director of Benefits, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Director of Benefits may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, which is done by publishing the summary annual report in the Union's newspaper.

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

### **Certificate of Creditable Coverage**

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **Prudent Action by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a benefit is denied or ignored in whole or in part, you have a right to receive a written explanation of the reason for the denial, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. You have the right to have the Plan or CIGNA - CareAllies review and reconsider your claim in accordance with the Appeal Procedures (see Appeal Procedures on page [45](#)).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, however, and, for example, the court finds your claim is frivolous, the court may order you to pay these costs and fees.

### **Assistance with your Questions**

If you have any questions about your Plan, you should contact the Director of Benefits, who oversees the daily administration of the AMO Medical Plan on behalf of the Board of Trustees.

If you have any question about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

### **SUBROGATION PROVISION**

The Plan has a repayment, assignment and subrogation provision. It is the claimant's responsibility as a participant in the Plan to protect the Plan's interest. The Plan requires reimbursement of benefits paid by the Plan out of any monies received by you from a third party regardless of how the recovery is classified and regardless of whether the participant or covered dependent receives only partial recovery for his or her claimed losses, it being the intent of this provision that the Plan has the right of first reimbursement out of any recovery the participant or covered dependent was able to obtain even if the participant or covered dependent was not made whole.

In consideration of the payment of benefits, a claimant will be required to execute an "Agreement of Repayment, Assignment and Subrogation" on behalf of the Plan if there is any possibility of recovery of benefits from a third party by the participant.

### **PRIVACY OF HEALTH INFORMATION**

The AMO Medical Plan has made every effort to protect and guard the privacy of its participants. The Plan has established procedures to limit the use and disclosure of protected health information of all its participants in accordance with regulations. Protected health information includes information that relates to an individual's health, health care, or payment for care, and information that identifies or could be used to identify the individual. A copy of the Plan's procedures regarding its privacy policy, as well as participants' rights to information and how to exercise those rights, is available by writing to the Director of Benefits at the Dania Beach Plan office.

### **AMENDMENT AND TERMINATION**

The Trustees reserve the right in their sole discretion, and without notice to Participants, Dependents, Employers, the Union or others affected thereby, but consistent with applicable Federal Laws and Regulations to:

- (A) terminate or amend any benefit or the amount or conditions with respect to any benefit, even though such termination or amendment affects claims which have already accrued; and
- (B) alter or postpone the method of payment of any benefit; and amend any other provisions of the Rules and Regulations governing the Medical Plan; and

(C) interpret and construe the provisions of the Rules and Regulations.

The Union and contributing employers also have the right to terminate, amend or modify the Plan.

**NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

The Plan complies with Federal law (the Newborns' and Mothers' Health Protection Act of 1996) that prohibits restricting benefits for a mother's or newborn child's hospital length of stay because of childbirth to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. The Plan does not require a physician to obtain authorization (pre-certification) from the Plan for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable).

**WOMEN'S HEALTH & CANCER RIGHTS ACT**

The Plan complies with the Women's Health and Cancer Rights Act of 1998 by providing benefits to members and dependents in connection with a mastectomy, and who elect breast reconstruction, subject to the terms and provisions of the Plan.

**RIGHT OF RECOVERY OF OVERPAYMENTS**

If for any reason the AMO Medical Plan makes overpayment(s) to or on behalf of a participant and/or eligible dependent(s) for medical services, the AMO Medical Plan has the right to recover such overpayments from among one or more of the following as the Plan determines: any person(s) to or for or with respect to whom such payments were made, any insurance companies, providers of service, and/or any other organizations. If such refund is not made to the Plan within the time specified in a written notice, the overpayment(s) will be deducted from the participant's and/or any eligible dependents' future medical benefits. The Plan will in any event have the right to take legal or other action to collect overpayment(s) upon due notice.

## **SCHEDULES OF BENEFITS**

TYPE A – Active Participants  
TYPE B – Pensioners Not Medicare Eligible  
TYPE C – Pensioners Medicare Eligible  
STM – Similar to Medicare

# SCHEDULE OF BENEFITS

## TYPE A - ACTIVE PARTICIPANTS

Effective January 1, 2008

### Summary of Participant Out-of-Pocket Requirements Active Participants

PLAN PROVISION	PPO (IN-NETWORK)	NON-PPO (OUT-OF NETWORK)
<p><u>IMPORTANT NOTE:</u></p> <p>All annual benefit limits are based on a calendar year.</p>	Services received from network providers	Services received from non-network providers
<p><u>Deductible:</u></p> <p>The term “deductible” shall mean a certain dollar amount of eligible expenses which the Participant and/or Dependent is required to pay before benefits are paid.</p>	<p>Inpatient Hospital \$300/Confinement</p>	
	<p>Medical: \$250/Individual \$500/Family</p>	
	<p>Prescription: \$100/Individual \$200/Family</p>	
<p><u>Co-Insurance:</u></p> <p>The term “co-insurance” shall mean a percentage of medical expenses shared by you and the Plan after you meet your deductible. Your co-insurance is based on eligible expenses (Usual, Customary and Reasonable and PPO Contracted Rates).</p>	<p>Participant and/or Dependent responsible for 10% of PPO contracted rate for eligible expenses unless otherwise stated</p> <p>Plan pays 90% of PPO contracted rate for eligible expenses unless otherwise stated</p>	<p>Participant and/or Dependent responsible for 30% of Usual, Customary and Reasonable (UCR) rate for eligible expenses unless otherwise stated, plus all charges over UCR and all ineligible charges</p> <p>Plan pays 70% of Usual, Customary and Reasonable (UCR) rate for eligible expenses unless otherwise stated</p>
<p><u>Co-payment (Co-pay):</u></p> <p>The term “co-payment or co-pay” shall mean a pre-determined dollar amount or percentage of eligible expenses which the Participant and/or Dependent is required to pay.</p>	See following Schedules for co-payment applicable for each service	See following Schedules for co-payment applicable for each service
<p><u>Co-insurance Maximum:</u></p> <p>The term “Co-insurance Maximum” shall mean the maximum amount you pay based on eligible expenses, excluding deductibles, co-payments and penalties, in a calendar year for co-insurance.</p>	<p>Individual - \$3,000 Family - \$6,000</p>	

AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
SUBJECT TO PPO RULES  
TYPE A - ACTIVE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	PPO BENEFITS (IN-NETWORK)		NON-PPO BENEFITS (OUT-OF-NETWORK)		VISIT/ DOLLAR LIMITA-TIONS	PRE-CERT REQD?
	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT		
<u>Hospital Benefit</u> Inpatient (Schedule A1)	Not subject to Annual Medical Deductible  \$300 Deductible per Hospital Confinement  10% of contracted rate after deductible	90% of contracted rate after deductible	Not subject to Annual Medical Deductible  \$300 Deductible per Hospital Confinement  30% of UCR after deductible	70% of UCR after deductible		Yes (Contact CIGNA)
<u>Hospital Benefit</u> Outpatient Hospital Services (Schedule A2)	Subject to Annual Medical Deductible  \$100 Co-payment per incident  10% of contracted rate after co-payment	90% of contracted rate after co-payment	Subject to Annual Medical Deductible  \$100 Co-payment per incident  30% of UCR after co-payment	70% of UCR after co-payment		Yes (Contact AMO Medical Plan)
<u>Hospital Benefit</u> Rehabilitation (Schedule A4)	Not subject to Annual Medical Deductible  \$300 Deductible per Hospital Confinement  10% of contracted rate after deductible	90% of contracted rate after deductible	Not subject to Annual Medical Deductible  \$300 Deductible per Hospital Confinement  30% of UCR after deductible	70% of UCR after deductible	90 days per person per incident	Yes (Contact CIGNA)
<u>Hospital Benefit</u> Psychiatric, Mental & Nervous Disorder (Schedule B)	Not subject to Annual Medical Deductible  \$300 Deductible per Hospital Confinement  10% of contracted rate after deductible	90% of contracted rate after deductible	Not subject to Annual Medical Deductible  \$300 Deductible per Hospital Confinement  30% of UCR after deductible	70% of UCR after deductible	Maximum 120 days per person per lifetime (includes partial hospitalization after annual calendar year deductible is met)	Yes (Contact AMO Medical Plan)
<u>Hospital Benefit</u> Alcohol & Substance Abuse (Schedule C)	Not subject to Annual Medical Deductible  \$300 Deductible per Hospital Confinement  10% of contracted rate after deductible	90% of contracted rate after deductible	Not subject to Annual Medical Deductible  \$300 Deductible per Hospital Confinement  30% of UCR after deductible	70% of UCR after deductible	Single Confinement up to 42 days per person per lifetime	Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u> Physician's Office Visit (Schedule D1)	Not subject to Annual Medical Deductible  \$20 co-payment per physician's office visit.  10% of contracted rate for medical services performed in the doctor's office.	100% of contracted rate after co-payment for physician's office visit.  90% of contracted rate for medical services performed in the physician's office.	Subject to Annual Medical Deductible  30% of UCR after deductible	70% of UCR after deductible		No
<u>Medical Benefit</u> Inpatient Services (Schedule D2)	Not subject to Annual Medical Deductible  10% of contracted rate	90% of contracted rate	Not subject to Annual Medical Deductible  30% of UCR	70% of UCR		No

- Once annual co-insurance maximum is met, in-network and out-of-network benefits for eligible expenses will be paid at 100% of the eligible contracted rate (in-network) or UCR (out-of-network).
- **Patient may be responsible for all ineligible expenses and/or charges over UCR.**

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AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
SUBJECT TO PPO RULES

TYPE A - ACTIVE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	PPO BENEFITS (IN-NETWORK)		NON-PPO BENEFITS (OUT-OF-NETWORK)		VISIT/ DOLLAR LIMITATION	PRE-CERT REQD?
	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT		
<u>Medical Benefit</u>  Chiropractic  (Schedule D3)	Not subject to Annual Medical Deductible  \$20 Co-payment per professional medical visit  10% of contracted rate after co-payment	90% of contracted rate after co-payment	Subject to Annual Medical Deductible  30% of UCR after deductible	70% of UCR after deductible	Maximum \$500 payable per person per calendar year	No
<u>Medical Benefit</u>  Outpatient Surgery  (Schedule D4)	<u>Surgeon</u>  Subject to Annual Medical Deductible  10% of contracted rate after deductible	<u>Surgeon</u>  90% of contracted rate after deductible	<u>Surgeon</u>  Subject to Annual Medical Deductible  30% of UCR after deductible	<u>Surgeon</u>  70% of UCR after deductible		Yes (Contact AMO Medical Plan)
	<u>Assistant Surgeon (MD/DO)</u>  Subject to Annual Medical Deductible  10% of Surgeon's contracted rate after deductible	<u>Assistant Surgeon (MD/DO)</u>  20% of Surgeon's contracted rate payable at 90% after deductible	<u>Assistant Surgeon (MD/DO)</u>  Subject to Annual Medical Deductible  30% of Surgeon's UCR after deductible	<u>Assistant Surgeon (MD/DO)</u>  20% of Surgeon's UCR payable at 70% after deductible		
	<u>Physician Assistant or Surgical Assistant</u>  Subject to Annual Medical Deductible  10% of Surgeon's contracted rate after deductible	<u>Physician Assistant or Surgical Assistant</u>  10% of Surgeon's contracted rate payable at 90% after deductible	<u>Physician Assistant or Surgical Assistant</u>  Subject to Annual Medical Deductible  30% of Surgeon's UCR after deductible	<u>Physician Assistant or Surgical Assistant</u>  10% of Surgeon's UCR payable at 70% after deductible		
<u>Medical Benefit</u>  Inpatient Surgery  (Schedule D5)	<u>Surgeon</u>  Not subject to Annual Medical Deductible  10% of contracted rate	<u>Surgeon</u>  90% of contracted rate	<u>Surgeon</u>  Not subject to Annual Medical Deductible  30% of UCR	<u>Surgeon</u>  70% of UCR		Yes (Contact AMO Medical Plan)
	<u>Assistant Surgeon (MD/DO)</u>  Not Subject to Annual Medical Deductible  10% of Surgeon's contracted rate	<u>Assistant Surgeon (MD/DO)</u>  20% of Surgeon's contracted rate payable at 90%	<u>Assistant Surgeon (MD/DO)</u>  Not Subject to Annual Medical Deductible  30% of Surgeon's UCR	<u>Assistant Surgeon (MD/DO)</u>  20% of Surgeon's UCR payable at 70%		
	<u>Physician Assistant or Surgical Assistant</u>  Not Subject to Annual Medical Deductible  10% of Surgeon's contracted rate	<u>Physician Assistant or Surgical Assistant</u>  10% of Surgeon's contracted rate payable at 90%	<u>Physician Assistant or Surgical Assistant</u>  Not Subject to Annual Medical Deductible  30% of Surgeon's UCR	<u>Physician Assistant or Surgical Assistant</u>  10% of Surgeon's UCR payable at 70%		

- Once annual co-insurance maximum is met, in-network and out-of-network benefits for eligible expenses will be paid at 100% of the eligible contracted rate (in-network) or UCR (out-of-network).
- **Patient may be responsible for all ineligible expenses and/or charges over UCR.**

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AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
SUBJECT TO PPO RULES

TYPE A - ACTIVE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	PPO BENEFITS (IN-NETWORK)		NON-PPO BENEFITS (OUT-OF-NETWORK)		VISIT/ DOLLAR LIMITATION	PRE-CERT REQD?
	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT		
<u>Medical Benefit</u> Home Health & Durable Medical Equipment (Schedule D6)	Subject to Annual Medical Deductible 10% of contracted rate after deductible	90% of contracted rate after deductible	Subject to Annual Medical Deductible 30% of UCR after deductible	70% of UCR after deductible		Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u> Diagnostic, Laboratory and X-ray (Schedule D7)	Subject to Annual Medical Deductible 10% of contracted rate after deductible	90% of contracted rate after deductible	Subject to Annual Medical Deductible 30% of UCR after deductible	70% of UCR after deductible		No
<u>Medical Benefit</u> Chemotherapy/ Radiation (Schedule D8)	Subject to Annual Medical Deductible 10% of contracted rate after deductible	90% of contracted rate after deductible	Subject to Annual Medical Deductible 30% of UCR after deductible	70% of UCR after deductible		Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u> Anesthesia <sup>1</sup> (Schedule D9)	<u>Anesthesiologist</u> Subject to Annual Medical Deductible 10% of contracted rate after deductible	<u>Anesthesiologist</u> 90% of contracted rate after deductible	<u>Anesthesiologist</u> Subject to Annual Medical Deductible 30% of UCR after deductible	<u>Anesthesiologist</u> 70% of UCR after deductible		No
	<u>CRNA</u> Subject to Annual Medical Deductible 10% of Anesthesiologist's contracted rate after deductible	<u>CRNA</u> 50% of Anesthesiologist's contracted rate payable at 90% after deductible	<u>CRNA</u> Subject to Annual Medical Deductible 30% of Anesthesiologist's UCR after deductible	<u>CRNA</u> 50% of Anesthesiologist's UCR payable at 70% after deductible		
<u>Medical Benefit</u> Urgent Care Services (Clinic Visits) (Schedule D10)	Subject to Annual Medical Deductible \$40 Co-Payment 10% of contracted rate after deductible and co-payment	90% of contracted rate after deductible and co-payment	Subject to Annual Medical Deductible No Co-payment 30% of UCR after deductible	70% of UCR after deductible		No
<u>Medical Benefit</u> Fertility Treatment Includes: • Services • Prescription Drugs (Schedule D11)	Subject to Annual Medical Deductible 10% of contracted rate after deductible	90% of contracted rate after deductible	Subject to Annual Medical Deductible 30% of UCR after deductible	70% if UCR after deductible	\$2,000 maximum per lifetime	Yes (Contact AMO Medical Plan)

- Once annual co-insurance maximum is met, in-network and out-of-network benefits for eligible expenses will be paid at 100% of the eligible contracted rate (in-network) or UCR (out-of-network).
- **Patient may be responsible for all ineligible expenses and/or charges over UCR.**

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<sup>1</sup> In the event that a participant receives inpatient or outpatient services at a facility within a PPO or PPN network and if the in-network provider refers a service to an out-of-network anesthesia provider of service, the Plan will pay benefits for the out-of-network anesthesia provider of service subject to the Plan's rate schedule for in-network anesthesia benefit

AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
SUBJECT TO PPO RULES

TYPE A - ACTIVE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	PPO BENEFITS (IN-NETWORK)		NON-PPO BENEFITS (OUT-OF-NETWORK)		VISIT/ DOLLAR LIMITATION	PRE-CERT REQD?
	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT		
<u>Medical Benefit</u> Therapeutic Services • Physical • Occupational • Speech • Cardiac/Rehab (Schedule D12)	Subject to Annual Medical Deductible  \$20 Co-payment per professional medical visit  10% of contracted rate after co-payment and deductible	90% of contracted rate after co-payment and deductible	Subject to Annual Medical Deductible  30% of UCR after deductible	70% if UCR after deductible	\$3,000 per person per type per year	Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u> Outpatient Services (Schedule D13)	Subject to Annual Medical Deductible  10% of contracted rate after deductible	90% of contracted rate after deductible	Subject to Annual Medical Deductible  30% of UCR after deductible	70% of UCR after deductible		No
<u>Medical Benefit</u> Preventative Care • Mammogram (Baseline > 40 years of age) • PSA (Baseline > 50 years of age) • Colonoscopy (Baseline > 50 years of age) • Annual Pap Diagnostic Services (Schedule D14)	Not Subject to Annual Medical Deductible  \$20 Co-payment per professional medical visit	100% of contracted rate	Subject to Annual Medical Deductible  30% of UCR	70% of UCR	One per person per calendar year	No
<u>Medical Benefit</u> Outpatient Behavioral Health Services • Psychiatric • Mental • Nervous Disorder (Schedule E1)	Subject to Annual Medical Deductible  \$20 Co-payment per professional medical visit  10% of contracted rate after co-payment and deductible	90% of contracted rate after co-payment and deductible	Subject to Annual Medical Deductible  30% of UCR after deductible	70% of UCR after deductible	Maximum 20 treatments per person per Calendar Year	No
<u>Medical Benefit</u> Inpatient Psychiatric, Mental & Nervous Disorder (Schedule E2)	Not Subject to Annual Medical Deductible  10% of contracted rate	90% of contracted rate	Not subject to Annual Medical Deductible  30% of UCR	70% of UCR	120 days per person per lifetime	Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u> Outpatient Alcohol & Substance Abuse (Schedule F1)	Subject to Annual Medical Deductible  \$20 Co-payment per professional medical visit  10% of contracted rate after co-payment and deductible	90% of contracted rate after co-payment and deductible	Subject to Annual Medical Deductible  30% of UCR after deductible	70% of UCR after deductible	Maximum 25 treatments per person per lifetime	No

- Once annual co-insurance maximum is met, in-network and out-of-network benefits for eligible expenses will be paid at 100% of the eligible contracted rate (in-network) or UCR (out-of-network).
- **Patient may be responsible for all ineligible expenses and/or charges over UCR.**

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AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
SUBJECT TO PPO RULES

TYPE A - ACTIVE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	PPO BENEFITS (IN-NETWORK)		NON-PPO BENEFITS (OUT-OF-NETWORK)		VISIT/DOLLAR LIMITATION	PRE-CERT REQD?
	DEDUCTIBLES/CO-PAYMENTS/CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	DEDUCTIBLES/CO-PAYMENTS/CO-INSURANCE	AMO MEDICAL PLAN BENEFIT		
<u>Medical Benefit</u> Inpatient Alcohol & Substance Abuse (Schedule F2)	Not Subject to Annual Medical Deductible  10% of contracted rate	90% of contracted rate	Not subject to Annual Medical Deductible  30% of UCR	70% of UCR	Single Confinement up to 42 days per person per lifetime	Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u> <u>Hospice Services</u> <u>(life expectancy of 6 months or less)</u> <u>(Schedule G1)</u>	Subject to Annual Medical Deductible  10% of contracted rate	90% of contracted rate	Subject to Annual Medical Deductible  30% of UCR	70% of UCR	As defined below	Yes (Contact AMO Medical Plan)

- Once annual co-insurance maximum is met, in-network and out-of-network benefits for eligible expenses will be paid at 100% of the eligible contracted rate (in-network) or UCR (out-of-network).
- **Patient may be responsible for all ineligible expenses and/or charges over UCR.**

**Hospice Services:**

This benefit is provided as part of a Hospice program for participants with a life expectancy of six (6) months or less and is recommended by a legally qualified physician. Includes coverage for participants who are confined as an inpatient in a Hospital, Skilled Nursing Facility, or Hospice, or who are receiving care on an outpatient basis from a hospice care agency. Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, and homemaker or caretaker services. Services not solely related to the care of the patient, including but not limited to: companion services for patient or other members of the family, transportation, housekeeping, and maintenance of the home.

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AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
NOT SUBJECT TO PPO RULES

TYPE A - ACTIVE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	VISIT/DOLLAR LIMITATION	PRE-CERT REQUIRED?
<u>Hospital Benefit</u>  Emergency Room (medical emergency)  (Schedule A3)	Subject to Annual Medical Deductible  \$60 Co-payment per professional medical visit  10% of contracted rate or UCR after co-payment and deductible	90% of contracted rate or UCR after co-payment and deductible	Medical Emergency – see definition on page <a href="#">13</a>	No
Ambulance Benefit  (Schedule K)	Subject to Annual Medical Deductible  10% of UCR after deductible	90% of UCR after deductible	Local ground transportation only.	No
Air Ambulance Benefit  (Schedule K1)	Subject to Annual Medical Deductible  10% of UCR for ground transport after deductible	90% of UCR for ground transport after deductible	Based on medical necessity; benefit is equivalent to cost of local ground transportation.	No
Death Benefit  (Schedule L1)	No Deductible  No Co-payment	\$50,000	Active Employees Only	No
Accidental Death & Dismemberment Benefit  (Schedule M1)	No Deductible  No Co-payment	\$25,000 or \$50,000 depending on nature of loss	Active Employees Only	No
TMJ Benefit  (Schedule N)	No Deductible  10% of UCR	90% of UCR	\$1,500 per person per lifetime	No
Prescription Drug Benefit  (Schedule O1)	<u>Participating Pharmacy</u> Subject to Annual Prescription Deductible  \$10 or 20% Co-payment, whichever is greater  <u>Non-Participating Pharmacy</u> Subject to Annual Prescription Deductible  \$10 or 20% of the otherwise eligible benefit whichever is greater, plus cost over contracted charges.	<u>Participating Pharmacy</u> 80% of Contracted Charges after Co-payment and Annual Prescription Deductible  <u>Non-Participating Pharmacy</u> 80% of otherwise eligible benefit (contracted charges) after Co- payment and Annual Prescription Deductible	30 day maximum supply for non- maintenance drugs and 90 day maximum supply for maintenance drugs.  Supply limitation may be extended for employees at sea not to exceed 180 days.  Dispense generic only unless specified other by doctor.	No
Specialty Drug Treatment Benefit  (Schedule O2)	Subject to Annual Medical Deductible  10% of UCR after deductible	90% of UCR after deductible		Yes (Contact AMO Medical Plan)
Nicotine Delivery Systems Benefit  (Schedule O3)	No Deductible  10% of UCR	90% of UCR	\$500 payable per person per lifetime	No
Dental Injury Expense  (Schedule P)	Subject to Annual Medical Deductible  10% of UCR after deductible	90% of UCR after deductible		No
Hearing Aid Benefit  (Schedule Q)	No Deductible  No Co-payment	\$1,000 for services and equipment. Every 3 calendar years	Active Employees Only	No

- Once annual co-insurance maximum is met, benefits for eligible expenses will be paid at 100% of UCR.
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AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
NOT SUBJECT TO PPO RULES

TYPE A - ACTIVE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	DEDUCTIBLES/CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	VISIT/ DOLLAR LIMITA- TION	PRE- CERT REQD?
Optical Benefit (Schedule R)	No Deductible No Co-payment	\$180 per person per calendar year Maximum accumulation of \$360 every 2 calendar years		No
Disability Benefit (Schedule S)	No Deductible No Co-payment	\$50 per week up to 39 weeks	Active Employees Only	No
Direct Reimbursement (DR) Dental Benefit (Schedule T)	No Deductible		\$2,000 maximum annual benefit per Active participant and eligible dependent per calendar year	No
	Not Subject to Annual Medical Co-Insurance Maximum	100% of first \$500 of dental expense (subject to UCR)		
	No co-insurance for first \$500 of dental expense (subject to UCR)	50% of next \$3,000 of dental expense (subject to UCR)		
Orthotics Benefit (Schedule V)	No Deductible 10% of UCR	90% of UCR	\$500 payable per family per lifetime	No
Scholarship Benefit (Schedule W)	No Deductible No Co-payment	\$3,000 per scholastic year		No

- Once annual co-insurance maximum is met, benefits for eligible expenses will be paid at 100% of UCR.
- **Patient may be responsible for all ineligible expenses and/or charges over UCR.**

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## SCHEDULE OF BENEFITS

### TYPE B - PENSIONER NOT MEDICARE ELIGIBLE

Effective January 1, 2008

### Summary of Participant Out-of-Pocket Requirements Pensioner Not Medicare Eligible

PLAN PROVISION	PPO (IN-NETWORK)	NON-PPO (OUT-OF NETWORK)
<p><b>IMPORTANT NOTE:</b></p> <p>All annual benefit limits are based on a calendar year.</p>	Services received from network providers	Services received from non-network providers
<p><b>Deductible:</b></p> <p>The term “deductible” shall mean a certain dollar amount of eligible expenses which the Participant and/or Dependent is required to pay before benefits are paid.</p>	<p><u>Inpatient Confinement</u> \$500/Confinement</p>	
	<p><u>Medical:</u> \$300/Individual \$600/Family</p>	
	<p><u>Prescription:</u> \$100/Individual \$200/Family</p>	
<p><b>Co-Insurance:</b></p> <p>The term “co-insurance” shall mean a percentage of medical expenses shared by you and the Plan after you meet your deductible. Your co-insurance is based on eligible expenses (Usual, Customary and Reasonable and PPO Contracted Rates).</p>	<p>Participant and/or Dependent responsible for 20% of PPO contracted rate for eligible expenses unless otherwise stated</p> <p>Plan pays 80% of PPO contracted rate for eligible expenses unless otherwise stated</p>	<p>Participant and/or Dependent responsible for 40% of Usual, Customary and Reasonable (UCR) rate for eligible expenses unless otherwise stated, plus all charges over UCR and all ineligible charges</p> <p>Plan pays 60% of Usual, Customary and Reasonable (UCR) rate for eligible expenses unless otherwise stated</p>
<p><b>Co-payment (Co-pay):</b></p> <p>The term “co-payment or co-pay” shall mean a pre-determined dollar amount or percentage of eligible expenses which the Participant and/or Dependent is required to pay.</p>	See following Schedules for co-payment applicable for each service	See following Schedules for co-payment applicable for each service

AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
SUBJECT TO PPO RULES

TYPE B – PENSIONER NOT MEDICARE ELIGIBLE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	PPO BENEFITS (IN-NETWORK)		NON-PPO BENEFITS (OUT-OF-NETWORK)		VISIT/ DOLLAR LIMITA-TIONS	PRE-CERT REQD?
	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT		
<u>Hospital Benefit</u> Inpatient (Schedule A1)	Not subject to Annual Medical Deductible  \$500 Deductible per Hospital Confinement  20% of contracted rate after deductible	80% of contracted rate after deductible	Not subject to Annual Medical Deductible  \$500 Deductible per Hospital Confinement  40% of UCR after deductible	60% of UCR after deductible		Yes (Contact CIGNA)
<u>Hospital Benefit</u> Outpatient Hospital Services (Schedule A2)	Subject to Annual Medical Deductible  \$200 Co-payment per incident  20% of contracted rate after co-payment	80% of contracted rate after co-payment	Subject to Annual Medical Deductible  \$200 Co-payment per incident  40% of UCR after co-payment	60% of UCR after co-payment		Yes (Contact AMO Medical Plan)
<u>Hospital Benefit</u> Rehabilitation (Schedule A4)	Not subject to Annual Medical Deductible  \$500 Deductible per Hospital Confinement  20% of contracted rate after deductible	80% of contracted rate after deductible	Not subject to Annual Medical Deductible  \$500 Deductible per Hospital Confinement  40% of UCR after deductible	60% of UCR after deductible	90 days per person per incident	Yes (Contact CIGNA)
<u>Hospital Benefit</u> Psychiatric, Mental & Nervous Disorder (Schedule B)	Not subject to Annual Medical Deductible  \$500 Deductible per Hospital Confinement  20% of contracted rate after deductible	80% of contracted rate after deductible	Not subject to Annual Medical Deductible  \$500 Deductible per Hospital Confinement  40% of UCR after deductible	60% of UCR after deductible	Maximum 120 days per person per lifetime (includes partial hospitalization after annual calendar year deductible is met)	Yes (Contact AMO Medical Plan)
<u>Hospital Benefit</u> Alcohol & Substance Abuse (Schedule C)	Not subject to Annual Medical Deductible  \$500 Deductible per Hospital Confinement  20% of contracted rate after deductible	80% of contracted rate after deductible	Not subject to Annual Medical Deductible  \$500 Deductible per Hospital Confinement  40% of UCR after deductible	60% of UCR after deductible	Single Confinement up to 42 days per person per lifetime	Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u> Physician's Office Visit (Schedule D1)	Not subject to Annual Medical Deductible  \$20 co-payment per physician's office visit.  20% of contracted rate for medical services performed in the doctor's office.	100% of contracted rate after co-payment for physician's office visit charge only.  80% of contracted rate for medical services performed in the physician's office.	Subject to Annual Medical Deductible  40% of UCR after deductible	60% of UCR after deductible		No
<u>Medical Benefit</u> Inpatient Services (Schedule D2)	Not subject to Annual Medical Deductible  20% of contracted rate	80% of contracted rate	Not subject to Annual Medical Deductible  40% of UCR	60% of UCR		No

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AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
SUBJECT TO PPO RULES

TYPE B – PENSIONER NOT MEDICARE ELIGIBLE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	PPO BENEFITS (IN-NETWORK)		NON-PPO BENEFITS (OUT-OF-NETWORK)		VISIT/DOLLAR LIMITATION	PRE-CERT REQD?
	DEDUCTIBLES/CO-PAYMENTS/CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	DEDUCTIBLES/CO-PAYMENTS/CO-INSURANCE	AMO MEDICAL PLAN BENEFIT		
<u>Medical Benefit</u> Chiropractic (Schedule D3)	Not Subject to Annual Medical Deductible \$20 Co-payment per professional medical visit 20% of contracted rate after co-payment	80% of contracted rate after co-payment	Subject to Annual Medical Deductible 40% of UCR after deductible	60% of UCR after deductible	Maximum \$500 payable per person per calendar year	No
<u>Medical Benefit</u> Outpatient Surgery (Schedule D4)	<u>Surgeon</u> Subject to Annual Medical Deductible 20% of contracted rate after deductible	<u>Surgeon</u> 80% of contracted rate after deductible	<u>Surgeon</u> Subject to Annual Medical Deductible 40% of UCR after deductible	<u>Surgeon</u> 60% of UCR after deductible		Yes (Contact AMO Medical Plan)
	<u>Assistant Surgeon (MD/DO)</u> Subject to Annual Medical Deductible 20% of Surgeon's contracted rate after deductible	<u>Assistant Surgeon (MD/DO)</u> 20% of Surgeon's contracted rate payable at 80% after deductible	<u>Assistant Surgeon (MD/DO)</u> Subject to Annual Medical Deductible 40% of Surgeon's UCR after deductible	<u>Assistant Surgeon (MD/DO)</u> 20% of Surgeon's UCR payable at 60% after deductible		
	<u>Physician Assistant or Surgical Assistant</u> Subject to Annual Medical Deductible 20% of Surgeon's contracted rate after deductible	<u>Physician Assistant or Surgical Assistant</u> 10% of Surgeon's contracted rate payable at 80% after deductible	<u>Physician Assistant or Surgical Assistant</u> Subject to Annual Medical Deductible 40% of Surgeon's UCR after deductible	<u>Physician Assistant or Surgical Assistant</u> 10% of Surgeon's UCR payable at 60% after deductible		
<u>Medical Benefit</u> Inpatient Surgery (Schedule D5)	<u>Surgeon</u> Not subject to Annual Medical Deductible 20% of contracted rate	<u>Surgeon</u> 80% of contracted rate	<u>Surgeon</u> Not subject to Annual Medical Deductible 40% of UCR	<u>Surgeon</u> 60% of UCR		Yes (Contact CIGNA)
	<u>Assistant Surgeon (MD/DO)</u> Not subject to Annual Medical Deductible 20% of Surgeon's contracted rate	<u>Assistant Surgeon (MD/DO)</u> 20% of Surgeon's contracted rate payable at 80%	<u>Assistant Surgeon (MD/DO)</u> Not subject to Annual Medical Deductible 40% of Surgeon's UCR	<u>Assistant Surgeon (MD/DO)</u> 20% of Surgeon's UCR payable at 60%		
	<u>Physician Assistant or Surgical Assistant</u> Not subject to Annual Medical Deductible 20% of Surgeon's contracted rate	<u>Physician Assistant or Surgical Assistant</u> 10% of Surgeon's contracted rate payable at 80%	<u>Physician Assistant or Surgical Assistant</u> Not subject to Annual Medical Deductible 40% of Surgeon's UCR	<u>Physician Assistant or Surgical Assistant</u> 10% of Surgeon's UCR payable at 60%		

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AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
SUBJECT TO PPO RULES

TYPE B – PENSIONER NOT MEDICARE ELIGIBLE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	PPO BENEFITS (IN-NETWORK)		NON-PPO BENEFITS (OUT-OF-NETWORK)		VISIT/ DOLLAR LIMITA-TIONS	PRE-CERT REQD?
	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT		
<u>Medical Benefit</u> Home Health & Durable Medical Equipment (Schedule D6)	Subject to Annual Medical Deductible 20% of contracted rate after deductible	80% of contracted rate after deductible	Subject to Annual Medical Deductible 40% of UCR after deductible	60% of UCR after deductible		Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u> Diagnostic, Laboratory and X-ray (Schedule D7)	Subject to Annual Medical Deductible 20% of contracted rate after deductible	80% of contracted rate after deductible	Subject to Annual Medical Deductible 40% of UCR after deductible	60% of UCR after deductible		No
<u>Medical Benefit</u> Chemotherapy/ Radiation (Schedule D8)	Subject to Annual Medical Deductible 20% of contracted rate after deductible	80% of contracted rate after deductible	Subject to Annual Medical Deductible 40% of UCR after deductible	60% of UCR after deductible		Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u> Anesthesia <sup>1</sup> (Schedule D9)	<u>Anesthesiologist</u> Subject to Annual Medical Deductible 20% of contracted rate after deductible	<u>Anesthesiologist</u> 80% of contracted rate after deductible	<u>Anesthesiologist</u> Subject to Annual Medical Deductible 40% of UCR after deductible	<u>Anesthesiologist</u> 60% of UCR after deductible		No
	<u>CRNA</u> Subject to Annual Medical Deductible 20% of Anesthesiologist's contracted rate after deductible	<u>CRNA</u> 50% of Anesthesiologist's contracted rate payable at 80% after deductible	<u>CRNA</u> Subject to Annual Medical Deductible 40% of Anesthesiologist's UCR after deductible	<u>CRNA</u> 50% of Anesthesiologist's UCR payable at 60% after deductible		
<u>Medical Benefit</u> Urgent Care Services (Clinic Visits) (Schedule D10)	Subject to Annual Medical Deductible \$40 Co-Payment 20% of contracted rate after deductible and co-payment	80% of contracted rate after deductible and co-payment	Subject to Annual Medical Deductible No Co-payment 40% of UCR after deductible	60% of UCR after deductible		No
<u>Medical Benefit</u> Fertility Treatment Includes: • Services • Prescription Drugs (Schedule D11)	Subject to Annual Medical Deductible 20% of contracted rate after deductible	80% of contracted rate after deductible	Subject to Annual Medical Deductible 40% of UCR after deductible	60% if UCR after deductible	\$2,000 maximum per lifetime	Yes (Contact AMO Medical Plan)

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<sup>1</sup> In the event that a participant receives inpatient or outpatient services at a facility within a PPO or PPN network and if the in-network provider refers a service to an out-of-network anesthesia provider of service, the Plan will pay benefits for the out-of-network anesthesia provider of service subject to the Plan's rate schedule for in-network anesthesia benefit

AMERICAN MARITIME OFFICERS MEDICAL PLAN  
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SUBJECT TO PPO RULES

TYPE B – PENSIONER NOT MEDICARE ELIGIBLE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	PPO BENEFITS (IN-NETWORK)		NON-PPO BENEFITS (OUT-OF-NETWORK)		VISIT/DOLLAR LIMITATION	PRE-CERT REQD?
	DEDUCTIBLES/CO-INSURANCE/CO-PAYMENTS	AMO MEDICAL PLAN BENEFIT	DEDUCTIBLES/CO-INSURANCE/CO-PAYMENTS	AMO MEDICAL PLAN BENEFIT		
<u>Medical Benefit</u>  Therapeutic Services <ul style="list-style-type: none"> <li>• Physical</li> <li>• Occupational</li> <li>• Speech</li> <li>• Cardiac/Rehab</li> </ul> (Schedule D12)	Subject to Annual Medical Deductible  \$20 Co-payment per professional medical visit  20% of contracted rate after co-payment and deductible	80% of contracted rate after co-payment and deductible	Subject to Annual Medical Deductible  40% of UCR after deductible	60% if UCR after deductible	\$3,000 per person per type per year	Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u>  Outpatient Services  (Schedule D13)	Subject to Annual Medical Deductible  20% of contracted rate after deductible	80% of contracted rate after deductible	Subject to Annual Medical Deductible  40% of UCR after deductible	60% of UCR after deductible		No
<u>Medical Benefit</u>  Preventative Care <ul style="list-style-type: none"> <li>• Mammogram (Baseline &gt; 40 years of age)</li> <li>• PSA (Baseline &gt; 50 years of age)</li> <li>• Colonoscopy (Baseline &gt; 50 years of age)</li> <li>• Annual Pap Diagnostic Services</li> </ul> (Schedule D14)	Not Subject to Annual Medical Deductible  \$20 Co-payment per professional medical visit	100% of UCR	Subject to Annual Medical Deductible  40% of UCR	60% of UCR	One per person per calendar year	No
<u>Medical Benefit</u>  Outpatient Psychiatric, Mental & Nervous Disorder  (Schedule E1)	Subject to Annual Medical Deductible  \$20 Co-payment per professional medical visit  20% of contracted rate after co-payment and deductible	80% of contracted rate after co-payment and deductible	Subject to Annual Medical Deductible  40% of UCR after deductible	60% of UCR after deductible	Maximum 20 treatments per person per Calendar Year	No
<u>Medical Benefit</u>  Inpatient Psychiatric, Mental & Nervous Disorder  (Schedule E2)	Not Subject to Annual Medical Deductible  20% of contracted rate	80% of contracted rate	Not subject to Annual Medical Deductible  40% of UCR	60% of UCR	120 days per person per lifetime	Yes (Contact AMO Medical Plan)

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TYPE B – PENSIONER NOT MEDICARE ELIGIBLE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	PPO BENEFITS (IN-NETWORK)		NON-PPO BENEFITS (OUT-OF-NETWORK)		VISIT/ DOLLAR LIMITATION	PRE-CERT REQD?
	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	DEDUCTIBLES/ CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT		
<u>Medical Benefit</u>  Outpatient Alcohol & Substance Abuse  (Schedule F1)	Subject to Annual Medical Deductible  \$20 Co-payment per professional medical visit  20% of contracted rate after co-payment and deductible	80% of contracted rate after co-payment and deductible	Subject to Annual Medical Deductible  40% of UCR after deductible	60% of UCR after deductible	Maximum 25 treatments per person per lifetime	No
<u>Medical Benefit</u>  Inpatient Alcohol & Substance Abuse  (Schedule F2)	Not Subject to Annual Medical Deductible  20% of contracted rate	80% of contracted rate	Not subject to Annual Medical Deductible  40% of UCR	60% of UCR	Single Confinement up to 42 days per person per lifetime	Yes (Contact AMO Medical Plan)
<u>Medical Benefit</u>  <u>Hospice Services</u> <u>(life expectancy of 6 months or less)</u>  (Schedule G1)	Subject to Annual Medical Deductible  20% of contracted rate	80% of contracted rate	Subject to Annual Medical Deductible  40% of contracted rate	60% of UCR	As defined below	Yes (Contact AMO Medical Plan)

**Hospice Services:**

This benefit is provided as part of a Hospice program for participants with a life expectancy of six (6) months or less and is recommended by a legally qualified physician. Includes coverage for participants who are confined as an inpatient in a Hospital, Skilled Nursing Facility, or Hospice, or who are receiving care on an outpatient basis from a hospice care agency. Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, and homemaker or caretaker services. Services not solely related to the care of the patient, including but not limited to: companion services for patient or other members of the family, transportation, housekeeping, and maintenance of the home.

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AMERICAN MARITIME OFFICERS MEDICAL PLAN  
SCHEDULE OF BENEFITS  
NOT SUBJECT TO PPO RULES

TYPE B - PENSIONER NOT MEDICARE ELIGIBLE PARTICIPANTS  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	DEDUCTIBLES/CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	VISIT/ DOLLAR LIMITATION	PRE-CERT REQD?
<u>Hospital Benefit</u> Emergency Room (medical emergency) (Schedule A3)	Subject to Annual Medical Deductible \$60 Co-payment per professional medical visit 20% of contracted rate or UCR after co-payment and deductible	80% of contracted rate or UCR after co-payment and deductible	Medical Emergency – see definition on page 13	No
Ambulance Benefit (Schedule K)	Subject to Annual Medical Deductible 20% of UCR after deductible	80% of UCR after deductible		No
Air Ambulance Benefit (Schedule K1)	Subject to Annual Medical Deductible 20% of UCR for ground transport after deductible	80% of UCR for ground transport after deductible	Based on medical necessity; benefit is equivalent to cost of local ground transportation.	No
TMJ Benefit (Schedule N)	No Deductible 20% of UCR	80% of UCR	\$1,500 per person per lifetime	No
Prescription Drug Benefit (Schedule O1)	<u>Participating Pharmacy</u> Subject to Annual Prescription Deductible \$10 or 20% Co-payment, whichever is greater  <u>Non-Participating Pharmacy</u> Subject to Annual Prescription Deductible \$10 or 20% of the otherwise eligible benefit whichever is greater, plus cost over contracted charges	<u>Participating Pharmacy</u> 80% of contracted rate after deductible and co-payment  <u>Non-Participating Pharmacy</u> 80% of otherwise eligible benefit (contracted charges) after deductible and co-payment	30 day maximum supply for non-maintenance drugs and 90 day maximum supply for maintenance drugs.  Dispense generic only unless specified other by doctor.	No
Specialty Drug Treatment Benefit (Schedule O2)	Subject to Annual Medical Deductible 20% of UCR after deductible	80% of UCR after deductible		Yes (Contact AMO Medical Plan)
Nicotine Delivery Systems Benefit (Schedule O3)	No Deductible 20% of UCR	80% of UCR	\$500 payable per person per lifetime	No
Dental Injury Expense (Schedule P)	Subject to Annual Medical Deductible 20% of UCR after deductible	80% of UCR after deductible		No
Optical Benefit (Schedule R)	No Deductible No Co-payment 100% UCR Optical Benefits are those in effect on the effective date of pension unless amended, modified or terminated, or unless the Trustees specifically provide otherwise			
Orthotics Benefit (Schedule V)	No Deductible 20% of UCR	80% of UCR	\$500 payable per family per lifetime	No
Scholarship Benefit (Schedule W)	No Deductible No Co-payment	\$3,000 per scholastic year		No
Scholarship Benefits are those in effect on the effective date of pension unless amended, modified or terminated, or unless the Trustees specifically provide otherwise				

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AMERICAN MARITIME OFFICERS MEDICAL PLAN  
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NOT SUBJECT TO PPO RULES

TYPE C – PENSIONER MEDICARE ELIGIBLE  
(Effective January 1, 2008)

BENEFIT DESCRIPTION	DEDUCTIBLES/CO-PAYMENTS/ CO-INSURANCE	AMO MEDICAL PLAN BENEFIT	VISIT/ DOLLAR LIMITATION	PRE-CERT REQD?
<u>Medical Benefit</u>  Physician's Office Visit  (Schedule D1)	Not subject to Annual Medical Deductible.  <p style="text-align: center;"><u>You pay:</u> 20% coinsurance for medical services performed in the doctor's office.</p>	The Plan will provide benefit payments secondary to Medicare, not to exceed 80% of the Medicare allowable rate.		No
Prescription Drug Benefit (includes Specialty Drug Treatment Benefit)  (Schedule O1)	<p style="text-align: center;">Participating Pharmacy            Subject to Annual Prescription Deductible</p> <p style="text-align: center;">\$10 or 20% Co-payment,            whichever is greater</p> <p style="text-align: center;">Non-Participating Pharmacy            Subject to Annual Prescription Deductible</p> <p style="text-align: center;">\$10 or 20% of the otherwise eligible benefit            whichever is greater, plus cost over            contracted charges.</p>	<p style="text-align: center;">Participating Pharmacy            80% of contracted rate after deductible            and co-payment</p> <p style="text-align: center;">Non-Participating Pharmacy            80% of otherwise eligible benefit            (contracted charges) after deductible and            co-payment</p>	30 day maximum supply for non- maintenance drugs and 90 day maximum supply for maintenance drugs.  Dispense generic only unless otherwise specified by doctor.	Yes (Contact AMO) Pre-certification required for all Specialty Drugs

**TYPE C SCHEDULE LIMITATIONS:**

- See PLAN TYPE B Schedule for Benefit LIMITATIONS AND EXCLUSIONS.
- The Plan will coordinate benefits with Medicare (Medicare is Primary) subject to Plan TYPE B Schedule (Out-of-Network) LIMITATIONS AND EXCLUSIONS.
- Benefits provided by the Plan in this Schedule AFTER DEDUCTIBLE consist of CO-INSURANCE of 20% of Medicare allowable for all benefits, with the exception of PHYSICIANS OFFICE VISITS (see Schedule D1 above).
- FERTILITY BENEFITS are excluded.
- PREVENTIVE CARE BENEFITS are excluded.
- OPTICAL AND SCHOLARSHIP BENEFITS are those in effect on the Pension Effective Date, unless amended, modified or terminated, or unless the Trustees provide otherwise.



**SIMILAR TO MEDICARE PENSIONER'S BENEFITS**

(Effective January 1, 2008)

The following is a summary of the benefits provided under the Medical Plan for retirees who are eligible for "Similar to Medicare" type benefits. The purpose of this summary is to convey important information and facilitate the processing of claims for benefit payment. This summary is not intended to interpret, extend or change in any way the Rules and Regulations of the Plan, which will govern in all cases. The Board of Trustees reserves the right to modify, amend or terminate these benefits.

<b>SCHEDULE</b>	<b>BENEFIT DESCRIPTION</b>	<b>BENEFIT</b> (Payment is based on Medicare Allowable.)
A1	Hospital or other facility	<u>Inpatient Hospital Deductible:</u> 1-60 days: \$1,024 deductible; 61-90 days: \$256 a day deductible. The Plan will pay for additional days (after 90 days) up to a maximum of 60 days per lifetime. The deductible on these days is \$512 a day. A new period starts if the current confinement is not related to prior one.
B	Inpatient Psychiatric, Mental & Nervous Disorder	120 days per lifetime.
C	Inpatient Alcohol & Substance Abuse	One confinement up to 42 days per person per lifetime.
D	Medical	A deductible of \$135/calendar year with payments of 80% Medicare Allowable after the deductible is met. Payment is for Medicare Allowable amount for each specific service or procedure.  Routine physical exams, routine foot care, routine eye exams, eyeglasses, and treatment for TMJ are not covered.  <i>Providers not covered: nurse anesthetist, unlicensed mental health practitioner, clinical social worker, physician assistant, and nurse practitioner.</i>
D3	Chiropractic	80% of Medicare Allowable. Maximum \$500 payable per person per calendar year.
D4 D5	Surgical	80% of Medicare Allowable. Exclusions: transplants with exception of corneas, kidneys, and skin. The deductible restrictions, and/or limitations under Schedule D4 and/or D5 will apply.
D7	Diagnostic, Laboratory and X-ray	80% of Medicare Allowable. The deductible restrictions, and/or limitations under Schedule D7 will apply.
D8	Chemotherapy/ Radiation	80% of Medicare Allowable. The deductible restrictions, and/or limitations under Schedule D8 will apply.
D12	Physical Therapy / Speech Therapy	\$1780 maximum per person per calendar year. The deductible restrictions and/or limitations under Schedule D1 will apply.
	Occupational Therapy	\$1780 maximum per person per calendar year. The deductible restrictions and/or limitations under Schedule D1 will apply.
E1	Outpatient Psychiatric	50% of Medicare Allowable. Maximum 25 treatments per person per lifetime. The deductible restrictions, and/or limitations under Schedule E1 will apply.
F1	Outpatient Drug & Alcohol	50% of Medicare Allowable. Maximum 25 treatments per person per lifetime. The deductible restrictions, and/or limitations under Schedule F1 will apply.
K	Ambulance	80% of Medicare Allowable. Restriction: only a professional ambulance is covered, for use locally. Locally shall mean ground transportation to the nearest facility equipped to handle the medical necessity. The limitations under Schedule K will apply.
V	Orthotics	\$500 maximum per family per lifetime. The limitations under Schedule V will apply.

- Prescription Drug Benefits are excluded under Similar to Medicare coverage.
- Patient may be responsible for all ineligible expenses and/or charges over UCR.

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