

AMO MEDICAL PLAN

BENEFIT ELIGIBILITY INFORMATION

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 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, 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 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, or the date the participant commences employment with an employer in the industry who is not obligated under a collective bargaining agreement to make contributions to the AMO Medical Plan on the participant's behalf; 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.

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 Card, will be required:

Status Change	Proof Required
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 Card that can be obtained from the Plan Office. The Plan makes use of the Permanent Data Card for two purposes: (1) to identify dependents and (2) to verify beneficiary(ies). 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. 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.

