AMERICAN MARITIME OFFICERS

MEDICAL PLAN

Summary Plan Description

January 1, 2012
Dear Plan Participant:

The Trustees of the American Maritime Officers (AMO) Medical Plan (the “Plan”) are pleased to present you with this updated Summary Plan Description (SPD) booklet summarizing your benefits under the Plan. 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.

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 SPD 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
IMPORTANT MESSAGE

HOW TO REQUEST A CERTIFICATE OF CREDITABLE COVERAGE

You have the right under federal law to obtain proof of the time you were covered under the American Maritime Officers Medical Plan (plan). That proof is called a certificate of creditable coverage. The plan will automatically provide you with a certificate when:

♦ Your coverage under the plan ends
♦ COBRA continuation coverage under the plan ends

The plan will also provide you with a certificate, upon request:

♦ At any time during which you are covered under the plan
♦ At any time during the 24 months after your coverage under the plan ends

Requests for a certificate of creditable coverage should be made to the plan. The request may be verbal or in writing. It should include: your name and participant number, the names of the individuals that need proof of coverage, and the address where the certificate should be sent.

CHANGES IN ELIGIBILITY

You should report ANY CHANGE IN ELIGIBILITY to the plan as soon as possible. Changes in eligibility include:

♦ Marriage or divorce
♦ Death of any dependent
♦ Birth or adoption of a child
♦ Dependent child reaching the limiting age
♦ Total disability
♦ Retirement
♦ Medicare eligibility

For specific details on maintaining coverage under the plan, refer to SECTION 3 - ELIGIBILITY.

GRANDFATHERED NOTICE

The AMO Medical Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Services Office at 800-348-6515 extension 12. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
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SECTION 1  MEDICAL BENEFITS
NOTE: UMR, Inc. is the plan's claims administrator. UMR, Inc. provides clerical and claim processing services to the plan. UMR, Inc. is not financially responsible for the funding or payment of claims processed under the plan, nor is UMR, Inc. a fiduciary to this plan.

**SCHEDULE OF BENEFITS**

**PRIOR AUTHORIZATION REQUIREMENTS**

The toll-free number for the department that handles the prior authorization requirements of your plan is shown on the back of your ID card. You should call as soon as possible to receive proper prior authorization. However, you must call within the time frames shown below. Please note this section does not apply to covered persons enrolled in Type C.

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<td>Inpatient Hospital</td>
<td>$250 per occurrence (the first penalty per covered person per lifetime will be waived). The penalty is taken prior to applying the deductible and coinsurance provisions of the plan. The penalty is not applied to the out-of-pocket limit.</td>
<td>You must call the number on the back of your ID card prior to any non-emergency inpatient admission. All inpatient admissions, except maternity admissions that do not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section delivery, require prior authorization. If you do not obtain prior authorization, benefits will be payable after the non-compliance penalty. If admission is on an emergency basis, you must call within two business days following your admission.</td>
<td>1-40</td>
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<tr>
<td>Psychological Disorder, Chemical Dependence, Alcoholism</td>
<td>$250 per occurrence (the first penalty per covered person per lifetime will be waived). The penalty is taken prior to applying the deductible and coinsurance provisions of the plan. The penalty is not applied to the out-of-pocket limit.</td>
<td>You must call the number on the back of your ID card to obtain prior authorization in advance of starting any inpatient treatment for a psychological disorder, chemical dependence or alcoholism. If you do not obtain prior authorization, benefits will be payable after the non-compliance penalty. If admission is on an emergency basis, you must call within two business days following your admission.</td>
<td>1-40</td>
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<tr>
<td>PRIOR AUTHORIZATION</td>
<td>NON-COMPLIANCE PENALTY</td>
<td>SUMMARY</td>
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<tr>
<td>Convalescent Nursing Home/Inpatient Rehabilitation Center</td>
<td>$250 per occurrence (the first penalty per covered person per lifetime will be waived). The penalty is taken prior to applying the deductible and coinsurance provisions of the plan. The penalty is not applied to the out-of-pocket limit.</td>
<td>You must call the number on the back of your ID card prior to a non-emergency admission. All inpatient admissions require prior authorization. If you do not obtain prior authorization, benefits will be payable after the non-compliance penalty. If admission is on an emergency basis, you must call within two business days following your admission.</td>
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<td>Organ Transplant</td>
<td>$250 per occurrence (the first penalty per covered person per lifetime will be waived). The penalty is taken prior to applying the deductible and coinsurance provisions of the plan. The penalty is not applied to the out-of-pocket limit.</td>
<td>You must call the number on the back of your ID card as soon as you become aware of the potential need for an organ transplant. In all cases, you must obtain prior authorization before the initial evaluation for a transplant. If you do not obtain prior authorization, benefits will be payable after the non-compliance penalty.</td>
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<tr>
<td>PRIOR AUTHORIZATION</td>
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</table>
| Outpatient Hospital and Outpatient Surgery | $250 per occurrence (the first penalty per *covered person* per *lifetime* will be waived). The penalty is taken prior to applying the deductible and coinsurance provisions of the *plan*. The penalty is not applied to the out-of-pocket limit. | You must call the number on the back of your ID card prior to receiving:  
- *outpatient hospital* surgery services (includes *ambulatory surgery center*)  
- MRI, MRA, CT scans, PET scans and SPECT scans (a single-photon emission computerized tomography)  
If you do not obtain *prior authorization*, benefits will be payable after the non-compliance penalty. If your treatment is on an *emergency* basis, you must call within two business days following your treatment.  
Please note the *prior authorization* requirement does not apply to:  
- other services received in an *outpatient hospital* setting  
- surgeries received in a *qualified practitioner’s office*  
- sleep studies, or  
- endoscopic surgeries (i.e. colonoscopy, sigmoidoscopy) whether received in an office or *outpatient* setting. | 1-40      |
<p>| Hospice Care                        | $250 per occurrence (the first penalty per <em>covered person</em> per <em>lifetime</em> will be waived). The penalty is taken prior to applying the deductible and coinsurance provisions of the <em>plan</em>. The penalty is not applied to the out-of-pocket limit. | You must call the number on the back of your ID card prior to starting any Hospice services. All Hospice services require <em>prior authorization</em>. If you do not obtain <em>prior authorization</em>, benefits will be payable after the non-compliance penalty. | 1-40      |</p>
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<td>Oral Surgery and Dental Injury</td>
<td>$250 per occurrence (the first penalty per covered person per lifetime will be waived).</td>
<td>You must call the number on the back of your ID card prior receiving oral surgery or prior to starting follow up care for a dental injury (for a dental injury, you are not required to provide prior authorization before the initial emergency treatment). If you do not obtain prior authorization, benefits will be payable after the non-compliance penalty. Please note that removal of wisdom teeth does not require prior authorization.</td>
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<td>$250 per occurrence (the first penalty per covered person per lifetime will be waived).</td>
<td>You must call the number on the back of your ID card prior to the purchase or rental of any item of durable medical equipment. If you do not obtain prior authorization, benefits will be payable after the non-compliance penalty. This requirement does not apply to orthotics.</td>
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<td>$250 per occurrence (the first penalty per covered person per lifetime will be waived).</td>
<td>You must call the number on the back of your ID card prior to starting any Home Health Care services. All Home Health Care services require prior authorization. If you do not obtain prior authorization, benefits will be payable after the non-compliance penalty.</td>
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<td>Fertility Treatments</td>
<td>$250 per occurrence (the first penalty per covered person per lifetime will be waived). The penalty is taken prior to applying the deductible and coinsurance provisions of the plan. The penalty is not applied to the out-of-pocket limit.</td>
<td>You must call the number on the back of your ID card prior to starting any fertility treatment, including prescription drug therapy. If you do not obtain prior authorization, benefits will be payable after the non-compliance penalty. Any testing received prior to the determination of the infertility diagnosis does not require prior authorization.</td>
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<td>Specialty Drug Treatments</td>
<td>No benefit is payable</td>
<td>For Type A and B only, you must call the plan prior to receiving any specialty drug. If you do not call, benefits will not be payable and you will be responsible for the entire cost of the specialty drug. Effective 8/1/12 For specialty pharmacy drugs that are dispensed in a qualified practitioner’s office or a qualified treatment facility, you must call the number on the back of your ID card for prior authorization before the purchase of a specialty pharmacy drug. If you do not call, benefits will not be payable and you will be responsible for the entire cost of the specialty drug. For specialty pharmacy drugs that are dispensed through a specialty pharmacy vendor, you must call the number on the back of your Prescription Drug Card for prior authorization before the purchase of a specialty pharmacy drug. If you do not call, benefits will not be payable and you will be responsible for the entire cost of the specialty drug.</td>
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</table>
| Therapy Services     | $250 per occurrence (the first penalty per covered person per lifetime will be waived). The penalty is taken prior to applying the deductible and coinsurance provisions of the plan. The penalty is not applied to the out-of-pocket limit. | *You must call the number on the back of your ID card after the 12th visit (per occurrence) for any of the following types of therapy:*  
  - physical therapy  
  - speech therapy  
  - occupational therapy  
  - cardiac rehabilitation  
  *If you do not obtain prior authorization, benefits will be payable after the non-compliance penalty.* | 1-40 |
| Chemo and Radiation Therapy | $250 per occurrence (the first penalty per covered person per lifetime will be waived). The penalty is taken prior to applying the deductible and coinsurance provisions of the plan. The penalty is not applied to the out-of-pocket limit. | *You must call the number on the back of your ID card prior to starting any chemo or radiation therapy, whether received in an office visit or outpatient hospital setting.*  
  *If you do not obtain prior authorization, benefits will be payable after the non-compliance penalty.* | 1-40 |
| Morbid Obesity Treatment | Not applicable | *You must call the plan for prior approval before receiving treatment for morbid obesity. Coverage is not available to all members, so please call the plan prior to receiving any treatment. Additional information will be provided when you call the plan for prior approval.* | |
Maternity Management – **Effective 6/1/12**

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| Maternity Management | No penalty              | Maternity Management is a prenatal care program. The program provides valuable wellness benefits to *you* and *your* unborn child.  

*You* should call during the first trimester of *your* pregnancy to participate in the Maternity Management program.  

There is no penalty for not participating in the Maternity Management program. However, if *you* do participate in the program through *your* entire pregnancy, the inpatient *hospital* copay for *your* inpatient *confinement* at the time of delivery will be waived. | 1-41 |
**MEDICAL BENEFITS**

Plan *Lifetime Maximum:* Unlimited

### TYPE A – ACTIVE BENEFITS

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<td>PPO</td>
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<tr>
<td>Individual</td>
<td>$0</td>
<td>$250</td>
<td>The amount you must pay each year before the <em>plan</em> will begin paying any benefits.</td>
<td>1-39</td>
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<td>Family</td>
<td>$0</td>
<td>$500</td>
<td>PPO and Non-PPO family maximums are calculated on a combined dollar basis for all <em>covered persons</em> in the family. No one <em>covered person</em> will incur more than the individual maximum shown.</td>
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<tr>
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<tr>
<th>Individual Coinsurance per Calendar Year</th>
<th></th>
<th></th>
<th>After the deductible, the coinsurance applies. After which the <em>plan</em> pays 100% of <em>covered expenses</em> subject to any maximums.</th>
<th>1-39</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>90%</td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-PPO</td>
<td>70%</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Pocket Limit per Calendar Year</th>
<th></th>
<th></th>
<th>Represents the total paid for the coinsurance (the deductible is in addition to this amount). After which the <em>plan</em> pays 100% of <em>covered expenses</em> subject to any maximums.</th>
<th>1-39</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$6,000</td>
<td><em>PPO</em> and <em>Non-PPO</em> family maximums are calculated on a combined dollar basis for all <em>covered persons</em> in the family. No one <em>covered person</em> will incur more than the individual maximum shown.</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td>This limit does not apply to benefit specific copays under the <em>plan</em>.</td>
<td></td>
</tr>
<tr>
<td>Non-PPO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$6,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Schedule of Benefits – continued

All covered expenses under the plan are payable at the plan's customary, usual and reasonable limits. The deductible and coinsurance limits shown above apply to all covered expenses unless stated otherwise below.

PPO Benefit Provision
PPO benefits will be payable for Non-PPO provider services only if:

1. You receive treatment for an emergency, including treatment received if you are admitted to the hospital directly from the emergency room;

2. You receive treatment that is a covered expense from a PPO provider and as a result of that treatment, a covered expense is incurred from an ancillary Non-PPO provider;

3. A PPO provider draws blood during an office visit but the sample is sent to a Non-PPO provider for testing;

4. The required medical services are not available from a PPO provider within 60 miles of the participant's residence.

Foreign Country
If you receive treatment in a foreign country from a doctor whose office is located in a hospital, the deductible will be waived. This only applies to office visit services. Any other benefits (hospitalization, surgery etc.) will be payable as any other sickness or injury.

<table>
<thead>
<tr>
<th>TYPE A COVERED EXPENSES</th>
<th>PAYABLE AT</th>
<th>BENEFIT SUMMARY</th>
<th>TEXT PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Benefit</td>
<td>PPO and Non-PPO: $300 hospital copay per confinement, then coinsurance, deductible waived</td>
<td>Semi-private room and board, intensive care or coronary care and miscellaneous charges.</td>
<td>1-42</td>
</tr>
<tr>
<td>Qualified Practitioner - Office Services Benefit Office Visit Charge</td>
<td>PPO: $20 copay per visit, then 100% Non-PPO: Subject to the deductible and coinsurance</td>
<td>Office visits are limited to one visit per day per qualified practitioner.</td>
<td>1-42</td>
</tr>
<tr>
<td>Any Other Covered Expense Received During the Office Visit (including independent lab charges and office surgery)</td>
<td>PPO: Subject to the coinsurance, deductible waived Non-PPO: Subject to the deductible and coinsurance</td>
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</tbody>
</table>

Revised 1/1/12
<table>
<thead>
<tr>
<th>TYPE A COVERED EXPENSES</th>
<th>PAYABLE AT</th>
<th>BENEFIT SUMMARY</th>
<th>TEXT PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Practitioner – Inpatient Benefits</td>
<td><em>PPO and Non-PPO: Subject to the deductible and coinsurance, deductible waived</em></td>
<td>Includes services such as inpatient <em>hospital</em> visits and inpatient surgical charges.</td>
<td>1-42</td>
</tr>
<tr>
<td>Qualified Practitioner – Outpatient Benefits</td>
<td><em>PPO and Non-PPO: Subject to the deductible and coinsurance</em></td>
<td>Includes services such as outpatient <em>hospital</em> visits and outpatient surgical charges.</td>
<td>1-42</td>
</tr>
<tr>
<td>Qualified Practitioner – Anesthesia Benefits</td>
<td><em>PPO and Non-PPO: Subject to the deductible and coinsurance</em></td>
<td>If two providers are billing for the same service, CRNA charges will be reimbursed at 50% of the anesthesiologist’s charges.</td>
<td>1-42</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td><em>PPO and Non-PPO: Payable as any other <em>sickness or injury</em>, at the <em>PPO</em> benefit level</em></td>
<td>Refer to list of covered oral surgeries in text. Prognathic or orthognathic surgery is a <em>covered expense</em> for any <em>covered person</em>.</td>
<td>1-42</td>
</tr>
<tr>
<td>Dental Injury</td>
<td><em>PPO and Non-PPO: Subject to the deductible and <em>PPO</em> coinsurance</em></td>
<td></td>
<td>1-43</td>
</tr>
<tr>
<td>TYPE A COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td>TEXT PAGE</td>
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</tr>
<tr>
<td>Wellness Benefit for Participants and Dependent Spouses&lt;br&gt;First Mammogram, Pap Smear and Pelvic Exam, PSA Test and Colonoscopy per Calendar Year (at or after baseline ages)</td>
<td>PPO: 100%, deductible, coinsurance and copays waived&lt;br&gt;Non-PPO: Subject to the deductible and coinsurance</td>
<td>Baseline ages are as follows:&lt;br&gt;• Mammogram – age 40&lt;br&gt;• Pap smear – no baseline age&lt;br&gt;• PSA – age 50&lt;br&gt;• Colonoscopy – age 50&lt;br&gt;Please refer to the text for additional information.</td>
<td>1-43</td>
</tr>
<tr>
<td>Any Additional Mammogram, Pap Smear and Pelvic Exam, PSA Test and Colonoscopy per Calendar Year (or if received prior to baseline ages)</td>
<td>PPO and Non-PPO: Payable as any other sickness or injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Routine Services</td>
<td>PPO and Non-PPO: Payable as any other sickness or injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu Shots Received at a Pharmacy</td>
<td>PPO and Non-PPO: Subject to the PPO coinsurance, deductible waived</td>
<td>You must pay for the flu shot and request reimbursement from the plan.</td>
<td></td>
</tr>
<tr>
<td>TYPE A COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td>TEXT PAGE</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
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<td>-----------</td>
</tr>
<tr>
<td>Wellness Benefit for Dependent Children</td>
<td></td>
<td>Please refer to the text for additional information.</td>
<td>1-43</td>
</tr>
<tr>
<td>Well Child Exam Charge</td>
<td>PPO: $20 copay per visit, then 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-PPO: Subject to the deductible and coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Other Routine Covered Expense Received During the Well Child Exam (including independent lab charges and office surgery)</td>
<td>PPO: Subject to the coinsurance, deductible waived</td>
<td>You must pay for the flu shot and request reimbursement from the plan.</td>
<td></td>
</tr>
<tr>
<td>Flu Shots Received at a Pharmacy</td>
<td>PPO and Non-PPO: Subject to the PPO coinsurance, deductible waived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Benefit</td>
<td>PPO and Non-PPO: $100 copay per date of service, then subject to the deductible and coinsurance</td>
<td>The copay only applies to the outpatient hospital facility charge for the following:</td>
<td>1-44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- MRI, MRA and all scans</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>All other outpatient hospital charges will be payable subject to the deductible and coinsurance.</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Benefit</td>
<td>PPO and Non-PPO: $60 copay per visit, then subject to the deductible and PPO coinsurance</td>
<td>The copay is waived if you are admitted to the hospital directly from the emergency room.</td>
<td>1-44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The copay applies to the facility charge only. Any other covered expenses received during your emergency room visit will be payable as any other sickness or injury at the PPO benefit level.</td>
<td></td>
</tr>
<tr>
<td>TYPE A COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td>TEXT PAGE</td>
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</tr>
</tbody>
</table>
| Urgent Care Center Benefits   | *PPO*: $40 copay per visit, then subject to the deductible and coinsurance  
<p>|                               | <em>Non-PPO</em>: Subject to the deductible and coinsurance |
|                               | Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all covered expenses performed during the visit. | 1-44      |
| Ambulatory Surgical Center    | <em>PPO</em> and <em>Non-PPO</em>: Subject to the deductible and coinsurance |                                                                                | 1-44      |
| X-ray and Laboratory Tests    | <em>PPO</em> and <em>Non-PPO</em>: Subject to the deductible and coinsurance | Dental x-rays limited to covered oral surgery or injury.                         | 1-44      |
| Ambulance Service Benefit     | <em>PPO</em> and <em>Non-PPO</em>: Subject to the deductible and <em>PPO</em> coinsurance | Limited to appropriate transport to the nearest facility equipped to treat the sickness or injury. | 1-44      |
| Pregnancy Benefit             | <em>PPO</em> and <em>Non-PPO</em>: Payable as any other sickness or injury | Covered for participants and dependent spouses only.                             | 1-44      |
| Newborn Benefits              | <em>PPO</em> and <em>Non-PPO</em>: Subject to the coinsurance, deductible waived | See &quot;Section 3 – Eligibility&quot; for important information on Dependent Coverage.    | 1-45      |
| Birthing Center Benefit       | <em>PPO</em> and <em>Non-PPO</em>: $300 hospital copay per confinement, then coinsurance, deductible waived |                                                                                | 1-45      |
| Convalescent Nursing Home Benefit | <em>PPO</em> and <em>Non-PPO</em>: $300 hospital copay per confinement, then coinsurance, deductible waived | Limited to 90 days per sickness or injury.                                       | 1-45      |</p>
<table>
<thead>
<tr>
<th>TYPE A COVERED EXPENSES</th>
<th>PAYABLE AT</th>
<th>BENEFIT SUMMARY</th>
<th>TEXT PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Rehabilitation Benefit</td>
<td>PPO and Non-PPO: $300 hospital copay per confinement, then coinsurance, deductible waived</td>
<td>Limited to 90 days per sickness or injury.</td>
<td>1-45</td>
</tr>
<tr>
<td>Home Health Care Benefit</td>
<td>PPO and Non-PPO: Subject to the deductible and coinsurance</td>
<td>60 visits per calendar year, when Home Health Care is in lieu of a covered confinement in a hospital or convalescent nursing home.</td>
<td>1-45</td>
</tr>
<tr>
<td>Hospice Care Benefit</td>
<td>PPO and Non-PPO: Subject to the deductible and coinsurance</td>
<td>Hospice care must be in lieu of a covered confinement in a hospital or convalescent nursing home.</td>
<td>1-46</td>
</tr>
<tr>
<td>Psychological Disorder Benefit</td>
<td></td>
<td></td>
<td>1-48</td>
</tr>
<tr>
<td>Inpatient Hospital (including transitional treatment)</td>
<td>PPO and Non-PPO: $300 hospital copay per confinement, then coinsurance, deductible waived</td>
<td>Inpatient/transitional treatment is limited to 120 days per lifetime. One inpatient day equals one transitional day.</td>
<td>1-48</td>
</tr>
<tr>
<td>Inpatient Qualified Practitioner</td>
<td>PPO and Non-PPO: Subject to the coinsurance, deductible waived</td>
<td>Inpatient hospital qualified practitioner visits will be allowed until the inpatient lifetime maximum has been met.</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>PPO: $20 copay per visit, then subject to the deductible and coinsurance</td>
<td>Outpatient treatment is limited to 20 visits per calendar year. Note: Transitional treatment may be applied to either the inpatient or outpatient visit maximum, based on how the charges are billed.</td>
<td></td>
</tr>
<tr>
<td>TYPE A COVERED EXPENSES</td>
<td>PAYABLE AT</td>
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<td>TEXT PAGE</td>
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</tr>
<tr>
<td>Chemical Dependence and Alcoholism Benefit</td>
<td><strong>PPO and Non-PPO:</strong> $300 hospital copay per confinement, then coinsurance, deductible waived</td>
<td>Inpatient/transitional treatment is limited to one confinement per lifetime, up to a maximum of 42 days during that confinement. One inpatient day equals one transitional day.</td>
<td>1-48</td>
</tr>
<tr>
<td>Inpatient Hospital (including transitional treatment)</td>
<td><strong>PPO and Non-PPO:</strong> Subject to the coinsurance, deductible waived</td>
<td>Inpatient hospital qualified practitioner visits will be allowed until the inpatient lifetime maximum has been met.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Qualified Practitioner</td>
<td><strong>PPO:</strong> $20 copay per visit, then subject to the deductible and coinsurance</td>
<td>Outpatient treatment is limited to 25 visits per lifetime.</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td><strong>Non-PPO:</strong> Subject to the deductible and coinsurance</td>
<td>Note: Transitional treatment may be applied to either the inpatient or outpatient visit maximum, based on how the charges are billed.</td>
<td></td>
</tr>
<tr>
<td>Other Covered Expenses</td>
<td></td>
<td>Items listed in the Other Covered Expenses section are payable as stated in the following boxes.</td>
<td>1-49</td>
</tr>
<tr>
<td>Medical Supplies and Implantable Medical Devices</td>
<td><strong>PPO and Non-PPO:</strong> Subject to the deductible and coinsurance</td>
<td>Includes items such as:</td>
<td>1-49</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• catheters</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• colostomy bags, belts and rings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• flotation pads</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• casts, splints, surgical dressings, trusses, braces and crutches,</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• oxygen and other gases</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• initial contact lenses or eyeglasses following cataract surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• pacemaker</td>
<td></td>
</tr>
<tr>
<td>Custom Molded Orthotics</td>
<td><strong>PPO and Non-PPO:</strong> Subject to the PPO coinsurance, deductible waived</td>
<td>Limited to $500 paid per lifetime.</td>
<td>1-49</td>
</tr>
<tr>
<td>TYPE A COVERED EXPENSES</td>
<td>PAYABLE AT</td>
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<tr>
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</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>PPO and Non-PPO: Subject to the deductible and coinsurance</td>
<td>Benefits for the rental of durable medical equipment will not exceed the cost to purchase the item</td>
<td>1-49</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>PPO: $20 copay per visit, then subject to the coinsurance, deductible waived Non-PPO: Subject to the deductible and coinsurance</td>
<td>Limited to $500 paid per calendar year. Chiropractic x-rays billed by a chiropractor are included in this maximum. X-rays received from a provider other than a chiropractor (such as a doctor of osteopathy or medical doctor) are not applied to the calendar year maximum. Routine or maintenance care is covered.</td>
<td>1-49</td>
</tr>
<tr>
<td>Treatment of Diabetes Diabetic Supplies</td>
<td>PPO and Non-PPO: Subject to the PPO deductible and PPO coinsurance</td>
<td>Diabetic supplies are payable through the medical plan when not covered by the Prescription Drug Card.</td>
<td>1-49</td>
</tr>
<tr>
<td>Diabetic Education Programs</td>
<td>PPO and Non-PPO: Payable as any other sickness or injury</td>
<td>Limited to the initial class only.</td>
<td>1-49</td>
</tr>
<tr>
<td>Insulin Infusion Pump</td>
<td>Payable at the same benefit level as durable medical equipment</td>
<td></td>
<td>1-49</td>
</tr>
<tr>
<td>Elective Sterilization</td>
<td>PPO and Non-PPO: Payable as any other sickness or injury</td>
<td></td>
<td>1-49</td>
</tr>
<tr>
<td>Physical, Speech, Occupational and Outpatient Cardiac Rehabilitation Therapy</td>
<td>PPO: $20 copay per visit, then subject to the deductible and coinsurance Non-PPO: Subject to the deductible and coinsurance</td>
<td>Physical, speech, occupational and outpatient cardiac rehabilitation therapy is limited to a combined maximum of 60 visits per calendar year. The copay applies per provider per date of service.</td>
<td>1-49</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>PPO and Non-PPO: Payable as any other sickness or injury</td>
<td></td>
<td>1-49</td>
</tr>
<tr>
<td>TYPE A COVERED EXPENSES</td>
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</tr>
<tr>
<td>Radiation and Chemo Therapy</td>
<td><em>PPO</em> and <em>Non-PPO</em>: Payable as any other <em>sickness</em> or <em>injury</em></td>
<td></td>
<td>1-49</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited to $500 paid per <em>calendar year</em>. Acupuncture is only a covered benefit when received from a <em>qualified practitioner</em>.</td>
<td>1-50</td>
</tr>
<tr>
<td>Acupuncture</td>
<td><em>PPO</em>: $20 copay per visit, then subject to the coinsurance, deductible waived</td>
<td><em>Non-PPO</em>: Subject to the deductible and coinsurance</td>
<td>1-50</td>
</tr>
<tr>
<td>Pre-Admission Testing</td>
<td><em>PPO</em> and <em>Non-PPO</em>: Subject to the deductible and coinsurance</td>
<td>For testing received within three days of your surgery.</td>
<td>1-50</td>
</tr>
<tr>
<td>Tissue Transplants</td>
<td><em>PPO</em>: Payable as any other <em>sickness</em> or <em>injury</em></td>
<td>Refer to list of covered tissue transplants in text.</td>
<td>1-50</td>
</tr>
<tr>
<td></td>
<td><em>Non-PPO</em>: Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ Transplants</td>
<td><em>PPO</em>: Payable as any other <em>sickness</em> or <em>injury</em></td>
<td>Refer to list of covered transplants in text and information about travel and lodging benefits.</td>
<td>1-50</td>
</tr>
<tr>
<td></td>
<td><em>Non-PPO</em>: Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TMJ Treatment</td>
<td><em>PPO</em> and <em>Non-PPO</em>: Subject to the <em>PPO</em> coinsurance, deductible waived</td>
<td>Limited to $1,500 paid per <em>lifetime</em>.</td>
<td>1-51</td>
</tr>
<tr>
<td>TYPE A COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
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</tr>
<tr>
<td>Infertility Treatment</td>
<td>PPO and Non-PPO: Subject to the deductible and coinsurance</td>
<td>Limited to $10,000 paid per lifetime for all treatment, including any prescription drugs. Covered expenses received in an office visit setting will be payable as stated in the Qualified Practitioner Office Services Benefit. Any testing prior to the determination of the infertility diagnosis does not apply to this maximum.</td>
<td>1-51</td>
</tr>
<tr>
<td>Hearing Benefit</td>
<td>PPO and Non-PPO: 100%, deductible and coinsurance waived</td>
<td>Limited to $1,000 paid every three calendar years. The hearing benefit includes: * routine hearing exams * hearing aids, include repair expenses Cochlear implants are covered as a medical expense and not included in the hearing benefit.</td>
<td>1-51</td>
</tr>
<tr>
<td>Nicotine Addiction</td>
<td>PPO and Non-PPO: Subject to the PPO coinsurance, deductible waived</td>
<td>Limited to $500 paid per lifetime. Covered expenses for office visits to obtain a prescription for nicotine addiction drugs are not included in the $500 maximum. Please refer to the text for additional information.</td>
<td>1-51</td>
</tr>
<tr>
<td>Birth Control Implants, Injections and Devices</td>
<td>PPO and Non-PPO: Payable as any other sickness or injury</td>
<td>Limited to covered participants and dependent spouses only. Other forms of birth control may be available through the Prescription Drug Card.</td>
<td>1-51</td>
</tr>
<tr>
<td>Eye Refractive Surgery</td>
<td>PPO and Non-PPO: 100%, deductible and coinsurance waived</td>
<td>Limited to $600 paid per lifetime.</td>
<td>1-51</td>
</tr>
<tr>
<td>Limitations and Exclusions</td>
<td>Not Payable</td>
<td>List of exclusions that apply to all covered expenses. A service that is normally covered may be excluded when provided with an excluded item.</td>
<td>1-53</td>
</tr>
<tr>
<td>TYPE A COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td>TEXT PAGE</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Prescription Drug Card Deductible per Calendar Year See Pharmacy Benefit section for further details</td>
<td>$100 individual&lt;br&gt;$200 family</td>
<td><strong>Copay</strong>&lt;br&gt;The greater of $10 or 20% copay per drug/refill.&lt;br&gt;If <em>you</em> are utilizing a Non-Participating Pharmacy, <em>covered expenses</em> will be reimbursed at 90% of the otherwise eligible benefit. <em>You</em> are also responsible for any amount over the contracted charges.&lt;br&gt;&lt;br&gt;<strong>Dispensing Limits</strong>&lt;br&gt;Limited to a 30-day supply. For active <em>participants</em> at sea, may receive up to a 180-day supply.&lt;br&gt;&lt;br&gt;<strong>Generic Substitution</strong>&lt;br&gt;If <em>you</em> choose to receive a brand name drug when a generic substitute is available, <em>you</em> will have to pay the difference between the cost of the brand name drug and the cost of the generic substitute in addition to the 20% copayment ($10 copay will not be applied). If <em>your qualified practitioner</em> will not allow a generic substitute, only the brand name copayment will apply.</td>
<td>1-58</td>
</tr>
<tr>
<td>TYPE A COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td>TEXT PAGE</td>
</tr>
<tr>
<td>------------------------</td>
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<td>-----------</td>
</tr>
</tbody>
</table>
| Specialty Drugs        | PPO and Non-PPO: Subject to the deductible and PPO coinsurance | Specialty pharmacy drugs are generally considered to:  
- cost more than $500 per prescription,  
- be administered by injection or infusion,  
- treat rare, unusual or complex diseases,  
- require additional clinical oversight and expertise for best management.  
Specialty drugs are payable through the medical plan and not the Prescription Drug Card. Specialty drugs dispensed in a qualified practitioner’s office are payable as any other sickness or injury.  
**Effective 8/1/12:** Specialty pharmacy drugs dispensed in a qualified practitioner’s office or a qualified treatment facility will continue to be payable by the medical plan. Effective 8/1/12, specialty pharmacy drugs dispensed through a specialty pharmacy vendor will be payable through the Prescription Drug Card. | |
| Dental and Vision Coverage | | Please refer to the Addendum to the American Maritime Officers Medical Plan Summary Plan Description for additional information. | |

Revised 1/1/12

1-20
Schedule of Benefits – continued

TYPE B – PENSIONER NOT MEDICARE ELIGIBLE BENEFITS

Eligibility for Type B is determined by the AMO Medical Plan Rules and Regulations, which includes annual earning limitation requirements. Pensioners and/or eligible dependents are required to submit to the plan (annually) a completed Permanent Data and Affidavit of Pensioner’s Medical Benefits Earnings Limitation and Coordination of Benefits form.

In the event that the pensioner or dependent earnings exceed the annual limitations established by the AMO Medical Plan Rules and Regulations, medical benefits will cease as of the date in such 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.

A pensioner who returns to employment aboard a vessel, including a return to Covered Employment, without permission from the Board of Trustees of the AMO Pension Plan, will forfeit all eligibility for benefits under the AMO Medical Plan.

<table>
<thead>
<tr>
<th>TYPE B MEDICAL BENEFITS</th>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
<th>BENEFIT SUMMARY</th>
<th>TEXT PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per Calendar Year</td>
<td></td>
<td></td>
<td>The amount you must pay each year before the plan will begin paying any benefits.</td>
<td>1-39</td>
</tr>
<tr>
<td>PPO</td>
<td></td>
<td></td>
<td>PPO and Non-PPO family maximums are calculated on a combined dollar basis for all covered persons in the family.  No one covered person will incur more than the individual maximum shown.</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$0</td>
<td>$300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$0</td>
<td>$600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-PPO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$0</td>
<td>$300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$0</td>
<td>$600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Coinsurance per</td>
<td></td>
<td></td>
<td>After the deductible, the coinsurance applies.</td>
<td>1-39</td>
</tr>
<tr>
<td>Calendar Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPO</td>
<td>80%</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-PPO</td>
<td>60%</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td></td>
<td></td>
<td>Type B does not have an out-of-pocket limit. After the deductible, covered expenses will continue to be reimbursed at the applicable coinsurance percentage for the remainder of the calendar year.</td>
<td></td>
</tr>
</tbody>
</table>
Schedule of Benefits – continued

All covered expenses under the plan are payable at the plan's customary, usual and reasonable limits. The deductible and coinsurance limits shown above apply to all covered expenses unless stated otherwise below.

**PPO Benefit Provision**

**PPO** benefits will be payable for Non-PPO provider services **only** if:

1. You receive treatment for an emergency, including treatment received if you are admitted to the hospital directly from the emergency room;
2. You receive treatment that is a covered expense from a PPO provider and as a result of that treatment, a covered expense is incurred from an ancillary Non-PPO provider;
3. A PPO provider draws blood during an office visit but the sample is sent to a Non-PPO provider for testing;
4. The required medical services are not available from a PPO provider within 60 miles of the participant’s residence.

**Foreign Country**

If you receive treatment in a foreign country from a doctor whose office is located in a hospital, the deductible will be waived. This only applies to office visit services. Any other benefits (hospitalization, surgery etc.) will be payable as any other sickness or injury.

<table>
<thead>
<tr>
<th>TYPE B COVERED EXPENSES</th>
<th>PAYABLE AT</th>
<th>BENEFIT SUMMARY</th>
<th>TEXT PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Benefit</td>
<td>PPO and Non-PPO: $500 hospital copay per confinement, then coinsurance, deductible waived</td>
<td>Semi-private room and board, intensive care or coronary care and miscellaneous charges.</td>
<td>1-42</td>
</tr>
<tr>
<td>Qualified Practitioner - Office Services Benefit Office Visit Charge</td>
<td>PPO: $20 copay per visit, then 100% Non-PPO: Subject to the deductible and coinsurance</td>
<td>Office visits are limited to one visit per day per qualified practitioner.</td>
<td>1-42</td>
</tr>
</tbody>
</table>

Any Other Covered Expense Received During the Office Visit (including independent lab charges and office surgery)

PPO: Subject to the coinsurance, deductible waived
Non-PPO: Subject to the deductible and coinsurance
<table>
<thead>
<tr>
<th>TYPE B COVERED EXPENSES</th>
<th>PAYABLE AT</th>
<th>BENEFIT SUMMARY</th>
<th>TEXT PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Practitioner – Inpatient Benefits</td>
<td>PPO and Non-PPO: Subject to the coinsurance, deductible waived</td>
<td>Includes services such as inpatient <em>hospital</em> visits and inpatient surgical charges.</td>
<td>1-42</td>
</tr>
<tr>
<td>Qualified Practitioner – Outpatient Benefits</td>
<td>PPO and Non-PPO: Subject to the deductible and coinsurance</td>
<td>Includes services such as outpatient <em>hospital</em> visits and outpatient surgical charges.</td>
<td>1-42</td>
</tr>
<tr>
<td>Qualified Practitioner – Anesthesia Benefits</td>
<td>PPO and Non-PPO: Subject to the deductible and coinsurance</td>
<td>If two providers are billing for the same service, CRNA charges will be reimbursed at 50% of the anesthesiologist’s charges.</td>
<td>1-42</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>PPO and Non-PPO: Payable as any other sickness or injury, at the PPO benefit level</td>
<td>Refer to list of covered oral surgeries in text. Prognathic or orthognathic surgery is a covered expense for any covered person.</td>
<td>1-42</td>
</tr>
<tr>
<td>Dental Injury</td>
<td>PPO and Non-PPO: Subject to the deductible and PPO coinsurance</td>
<td></td>
<td>1-43</td>
</tr>
<tr>
<td>TYPE B COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
| Wellness Benefit for Participants and Dependent Spouses | | Baseline ages are as follows:  
  • Mammogram – age 40  
  • Pap smear – no baseline age  
  • PSA – age 50  
  • Colonoscopy – age 50  

Please refer to the text for additional information. |
| First Mammogram, Pap Smear and Pelvic Exam, PSA Test and Colonoscopy per Calendar Year (at or after baseline ages) | *PPO*: 100%, deductible, coinsurance and copays waived  
*Non-PPO*: Subject to the deductible and coinsurance | |
| Any Additional Mammogram, Pap Smear and Pelvic Exam, PSA Test and Colonoscopy per Calendar Year (or if received prior to baseline ages) | *PPO* and *Non-PPO*: Payable as any other sickness or injury | |
| All Other Routine Services | *PPO* and *Non-PPO*: Payable as any other sickness or injury | |
| Flu Shots Received at a Pharmacy | *PPO* and *Non-PPO*: Subject to the *PPO* coinsurance, deductible waived | *You* must pay for the flu shot and request reimbursement from the plan. |

Baseline ages are as follows:  
• Mammogram – age 40  
• Pap smear – no baseline age  
• PSA – age 50  
• Colonoscopy – age 50  

Please refer to the text for additional information.
<table>
<thead>
<tr>
<th>TYPE B COVERED EXPENSES</th>
<th>PAYABLE AT</th>
<th>BENEFIT SUMMARY</th>
<th>TEXT PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness Benefit for Dependent Children</td>
<td></td>
<td>Please refer to the text for additional information.</td>
<td>1-43</td>
</tr>
<tr>
<td>Well Child Exam Charge</td>
<td><em>PPO</em>: $20 copay per visit, then 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Non-PPO</em>: Subject to the deductible and coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Other Routine Covered Expense Received During the Well Child Exam (including independent lab charges and office surgery)</td>
<td><em>PPO</em>: Subject to the coinsurance, deductible waived</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Non-PPO</em>: Subject to the deductible and coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu Shots Received at a Pharmacy</td>
<td><em>PPO</em> and <em>Non-PPO</em>: Subject to the <em>PPO</em> coinsurance, deductible waived</td>
<td>You must pay for the flu shot and request reimbursement from the plan.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Benefit</td>
<td><em>PPO</em> and <em>Non-PPO</em>: $200 copay per date of service, then subject to the deductible and coinsurance</td>
<td>The copay only applies to the <em>outpatient hospital</em> facility charge for the following:</td>
<td>1-44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• MRI, MRA and all scans</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>All other <em>outpatient hospital</em> charges will be payable subject to the deductible and coinsurance.</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Benefit</td>
<td><em>PPO</em> and <em>Non-PPO</em>: $60 copay per visit, then subject to the deductible and <em>PPO</em> coinsurance</td>
<td>The copay is waived if you are admitted to the <em>hospital</em> directly from the <em>emergency room</em>. The copay applies to the facility charge only. Any other <em>covered expenses</em> received during your <em>emergency room</em> visit will be payable as any other <em>sickness or injury</em> at the <em>PPO</em> benefit level.</td>
<td>1-44</td>
</tr>
<tr>
<td>TYPE B COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td>TEXT PAGE</td>
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</tr>
</tbody>
</table>
| Urgent Care Center Benefits | *PPO:* $40 copay per visit, then subject to the deductible and coinsurance  
*Non-PPO:* Subject to the deductible and coinsurance | Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all covered expenses performed during the visit. | 1-44 |
<p>| Ambulatory Surgical Center | <em>PPO and Non-PPO:</em> Subject to the deductible and coinsurance | | 1-44 |
| X-ray and Laboratory Tests | <em>PPO and Non-PPO:</em> Subject to the deductible and coinsurance | Dental x-rays limited to covered oral surgery or injury. | 1-44 |
| Ambulance Service Benefit | <em>PPO and Non-PPO:</em> Subject to the deductible and PPO coinsurance | Limited to appropriate transport to the nearest facility equipped to treat the sickness or injury. | 1-44 |
| Pregnancy Benefit | <em>PPO and Non-PPO:</em> Payable as any other sickness or injury | Covered for participants and dependent spouses only. | 1-44 |
| Newborn Benefits | <em>PPO and Non-PPO:</em> Subject to the coinsurance, deductible waived | See &quot;Section 3 – Eligibility&quot; for important information on Dependent Coverage. | 1-45 |
| Birthing Center Benefit | <em>PPO and Non-PPO:</em> $500 hospital copay per confinement, then coinsurance, deductible waived | | 1-45 |
| Convalescent Nursing Home Benefit | <em>PPO and Non-PPO:</em> $500 hospital copay per confinement, then coinsurance, deductible waived | Limited to 90 days per sickness or injury. | 1-45 |</p>
<table>
<thead>
<tr>
<th>TYPE B COVERED EXPENSES</th>
<th>PAYABLE AT</th>
<th>BENEFIT SUMMARY</th>
<th>TEXT PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Rehabilitation Benefit</td>
<td><em>PPO and Non-PPO:</em> $500 hospital copay per <em>confinement</em>, then coinsurance, deductible waived</td>
<td>Limited to 90 days per <em>sickness</em> or <em>injury</em>.</td>
<td>1-45</td>
</tr>
<tr>
<td>Home Health Care Benefit</td>
<td><em>PPO and Non-PPO:</em> Subject to the deductible and coinsurance</td>
<td>60 visits per <em>calendar year</em>, when Home Health Care is in lieu of a covered <em>confinement</em> in a hospital or convalescent nursing home.</td>
<td>1-45</td>
</tr>
<tr>
<td>Hospice Care Benefit</td>
<td><em>PPO and Non-PPO:</em> Subject to the deductible and coinsurance</td>
<td>Hospice care must be in lieu of a covered <em>confinement</em> in a hospital or convalescent nursing home.</td>
<td>1-46</td>
</tr>
<tr>
<td>Psychological Disorder Benefit</td>
<td>Inpatient Hospital (including transitional treatment)</td>
<td><em>PPO and Non-PPO:</em> $500 hospital copay per <em>confinement</em>, then coinsurance, deductible waived</td>
<td>Inpatient/transitional treatment is limited to 120 days per <em>lifetime</em>. One inpatient day equals one transitional day.</td>
</tr>
<tr>
<td></td>
<td>Inpatient Qualified Practitioner</td>
<td><em>PPO and Non-PPO:</em> Subject to the coinsurance, deductible waived</td>
<td>Inpatient <em>hospital qualified practitioner</em> visits will be allowed until the inpatient <em>lifetime</em> maximum has been met.</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td><em>PPO:</em> $20 copay per visit, then subject to the deductible and coinsurance</td>
<td>Outpatient treatment is limited to 20 visits per <em>calendar year</em>. Note: Transitional treatment may be applied to either the inpatient or outpatient visit maximum, based on how the charges are billed.</td>
</tr>
<tr>
<td>TYPE B COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td>TEXT PAGE</td>
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</tr>
<tr>
<td>Chemical Dependence and Alcoholism Benefit Inpatient Hospital (including transitional treatment)</td>
<td>PPO and Non-PPO: $500 hospital copay per confinement, then coinsurance, deductible waived</td>
<td>Inpatient/transitional treatment is limited to one confinement per lifetime, up to a maximum of 42 days during that confinement. One inpatient day equals one transitional day.</td>
<td>1-48</td>
</tr>
<tr>
<td>Inpatient Qualified Practitioner</td>
<td>PPO and Non-PPO: Subject to the coinsurance, deductible waived</td>
<td>Inpatient hospital qualified practitioner visits will be allowed until the inpatient lifetime maximum has been met.</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>PPO: $20 copay per visit, then subject to the deductible and coinsurance Non-PPO: Subject to the deductible and coinsurance</td>
<td>Outpatient treatment is limited to 25 visits per lifetime. Note: Transitional treatment may be applied to either the inpatient or outpatient visit maximum, based on how the charges are billed.</td>
<td></td>
</tr>
<tr>
<td>Other Covered Expenses</td>
<td></td>
<td>Items listed in the Other Covered Expenses section are payable as stated in the following boxes.</td>
<td>1-49</td>
</tr>
<tr>
<td>Medical Supplies and Implantable Medical Devices</td>
<td>PPO and Non-PPO: Subject to the deductible and coinsurance</td>
<td>Includes items such as:  - catheters  - colostomy bags, belts and rings  - flotation pads  - casts, splints, surgical dressings, trusses, braces and crutches,  - oxygen and other gases  - initial contact lenses or eyeglasses following cataract surgery  - pacemaker</td>
<td>1-49</td>
</tr>
<tr>
<td>Custom Molded Orthotics</td>
<td>PPO and Non-PPO: Subject to the PPO coinsurance, deductible waived</td>
<td>Limited to $500 paid per lifetime.</td>
<td>1-49</td>
</tr>
<tr>
<td>TYPE B COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td>TEXT PAGE</td>
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</tr>
<tr>
<td>Durable Medical Equipment</td>
<td><em>PPO</em> and <em>Non-PPO</em>: Subject to the deductible and coinsurance</td>
<td>Benefits for the rental of durable medical equipment will not exceed the cost to purchase the item</td>
<td>1-49</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td><em>PPO</em>: $20 copay per visit, then subject to the coinsurance, deductible waived&lt;br&gt;&lt;br&gt;<em>Non-PPO</em>: Subject to the deductible and coinsurance</td>
<td>Limited to $500 paid per calendar year. Chiropractic x-rays billed by a chiropractor are included in this maximum. X-rays received from a provider other than a chiropractor (such as a doctor of osteopathy or medical doctor) are not applied to the calendar year maximum. Routine or maintenance care is covered.</td>
<td>1-49</td>
</tr>
<tr>
<td>Treatment of Diabetes</td>
<td><em>PPO</em> and <em>Non-PPO</em>: Subject to the <em>PPO</em> deductible and <em>PPO</em> coinsurance</td>
<td>Diabetic supplies are payable through the medical plan when not covered by the Prescription Drug Card.</td>
<td>1-49</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td><em>PPO</em> and <em>Non-PPO</em>: Payable as any other <em>sickness or injury</em></td>
<td>Limited to the initial class only.</td>
<td></td>
</tr>
<tr>
<td>Diabetic Education Programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin Infusion Pump</td>
<td>Payable at the same benefit level as durable medical equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective Sterilization</td>
<td><em>PPO</em> and <em>Non-PPO</em>: Payable as any other <em>sickness or injury</em></td>
<td></td>
<td>1-49</td>
</tr>
<tr>
<td>Physical, Speech, Occupational and Outpatient Cardiac Rehabilitation Therapy</td>
<td><em>PPO</em>: $20 copay per visit, then subject to the deductible and coinsurance&lt;br&gt;&lt;br&gt;<em>Non-PPO</em>: Subject to the deductible and coinsurance</td>
<td>Physical, speech, occupational and outpatient cardiac rehabilitation therapy is limited to a combined maximum of 60 visits per calendar year. The copay applies per provider per date of service.</td>
<td>1-49</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td><em>PPO</em> and <em>Non-PPO</em>: Payable as any other <em>sickness or injury</em></td>
<td></td>
<td>1-49</td>
</tr>
<tr>
<td>TYPE B COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
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</tr>
<tr>
<td>Radiation and Chemo Therapy</td>
<td><strong>PPO and Non-PPO:</strong> Payable as any other <em>sickness or injury</em></td>
<td>Limited to $500 paid per <em>calendar year</em>. Acupuncture is only a covered benefit when received from a <em>qualified practitioner</em>.</td>
<td>1-49</td>
</tr>
<tr>
<td>Acupuncture</td>
<td><strong>PPO:</strong> $20 copay per visit, then subject to the coinsurance, deductible waived</td>
<td>For testing received within three days of <em>your surgery</em>.</td>
<td>1-50</td>
</tr>
<tr>
<td></td>
<td><strong>Non-PPO:</strong> Subject to the deductible and coinsurance</td>
<td>Refer to list of covered tissue transplants in text.</td>
<td>1-50</td>
</tr>
<tr>
<td>Pre-Admission Testing</td>
<td><strong>PPO and Non-PPO:</strong> Subject to the deductible and coinsurance</td>
<td>Refer to list of covered tissue transplants in text.</td>
<td>1-50</td>
</tr>
<tr>
<td>Tissue Transplants</td>
<td><strong>PPO:</strong> Payable as any other <em>sickness or injury</em></td>
<td>Limited to $1,500 paid per <em>lifetime</em>.</td>
<td>1-51</td>
</tr>
<tr>
<td>TMJ Treatment</td>
<td><strong>PPO and Non-PPO:</strong> Subject to the <strong>PPO</strong> coinsurance, deductible waived</td>
<td>Limited to $10,000 paid per <em>lifetime</em> for all treatment, including any prescription drugs. <em>Covered expenses</em> received in an office visit setting will be payable as stated in the Qualified Practitioner Office Services Benefit. Any testing prior to the determination of the infertility diagnosis does not apply to this maximum.</td>
<td>1-51</td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td><strong>PPO and Non-PPO:</strong> Subject to the deductible and coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TYPE B COVERED EXPENSES</td>
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</tr>
<tr>
<td>Nicotine Addiction</td>
<td><em>PPO and Non-PPO:</em> Subject to the PPO coinsurance, deductible waived</td>
<td>Limited to $500 paid per lifetime. Covered expenses for office visits to obtain a prescription for nicotine addiction drugs are not included in the $500 maximum. Please refer to the text for additional information.</td>
<td>1-51</td>
</tr>
<tr>
<td>Birth Control Implants, Injections and Devices</td>
<td><em>PPO and Non-PPO:</em> Payable as any other sickness or injury</td>
<td>Limited to covered participants and dependent spouses only. Other forms of birth control may be available through the Prescription Drug Card.</td>
<td>1-51</td>
</tr>
<tr>
<td>Eye Refractive Surgery</td>
<td><em>PPO and Non-PPO:</em> 100%, deductible and coinsurance waived</td>
<td>Limited to $600 paid per lifetime.</td>
<td>1-51</td>
</tr>
<tr>
<td>Limitations and Exclusions</td>
<td>Not Payable</td>
<td>List of exclusions that apply to all covered expenses. A service that is normally covered may be excluded when provided with an excluded item.</td>
<td>1-53</td>
</tr>
<tr>
<td>TYPE B COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td>TEXT PAGE</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------</td>
<td>----------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Prescription Drug Card</td>
<td>$100 individual</td>
<td>Copay</td>
<td>1-58</td>
</tr>
<tr>
<td>Deductible per Calendar Year</td>
<td>$200 family</td>
<td>The greater of $10 or 20% copay per drug/refill.</td>
<td></td>
</tr>
<tr>
<td>See Pharmacy Benefit section for further details</td>
<td>This deductible is separate from the medical plan deductible.</td>
<td>If you are utilizing a Non-Participating Pharmacy, covered expenses will be reimbursed at 80% of the otherwise eligible benefit. You are also responsible for any amount over the contracted charges.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Then 100% after copay.</td>
<td><strong>Dispensing Limits</strong> Limited to a 30-day supply. For active participants at sea, may receive up to a 180-day supply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Generic Substitution</strong> If you choose to receive a brand name drug when a generic substitute is available, you will have to pay the difference between the cost of the brand name drug and the cost of the generic substitute in addition to the 20% copayment ($10 copay will not be applied). If your qualified practitioner will not allow a generic substitute, only the brand name copayment will apply.</td>
<td></td>
</tr>
<tr>
<td>TYPE B COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
<td>TEXT PAGE</td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
</tbody>
</table>
| Specialty Drugs        | PPO and Non-PPO: Subject to the deductible and PPO coinsurance | Specialty pharmacy drugs are generally considered to:  
  - cost more than $500 per prescription,  
  - be administered by injection or infusion,  
  - treat rare, unusual or complex diseases,  
  - require additional clinical oversight and expertise for best management.  
  Specialty drugs are payable through the medical plan and not the Prescription Drug Card. Specialty drugs dispensed in a qualified practitioner’s office are payable as any other sickness or injury.  
  **Effective 8/1/12:** Specialty pharmacy drugs dispensed in a qualified practitioner’s office or a qualified treatment facility will continue to be payable by the medical plan. Effective 8/1/12, specialty pharmacy drugs dispensed through a specialty pharmacy vendor will be payable through the Prescription Drug Card. | |
| Dental and Vision Coverage | | Please refer to the Addendum to the American Maritime Officers Medical Plan Summary Plan Description for additional information. | |
TYPE C – PENSIONER MEDICARE ELIGIBLE BENEFITS EFFECTIVE 1/1/12 TO 9/30/12

The prior authorization requirements beginning on page 1-1 do not apply to participants who have Medicare as their primary coverage. You must call the number on the back of your pharmacy card prior to purchasing any specialty pharmacy medications or benefits will not be payable by the plan.

A pensioner who returns to employment aboard a vessel, including a return to Covered Employment, without permission from the Board of Trustees of the AMO Pension Plan, will forfeit all eligibility for benefits under the AMO Medical Plan.

Type C is a match to Type B PPO benefits with the exception of the following:

<table>
<thead>
<tr>
<th>TYPE C MEDICAL BENEFITS</th>
<th>PLAN PAYS</th>
<th>YOU PAY</th>
<th>BENEFIT SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Practitioner Office Visit</td>
<td>The plan will provide benefit payments secondary to Medicare, not to exceed 80% of the Medicare allowable rate.</td>
<td>Not subject to the calendar year deductible. You pay 20% coinsurance for covered expenses received in the office</td>
<td>Payable through the EnvisionRx Plus program.</td>
</tr>
<tr>
<td>Prescription Drug Benefits, Including Specialty Pharmacy</td>
<td>See Pharmacy Benefit section for further details</td>
<td></td>
<td>In the event that you enroll in any Medicare Part D prescription drug plan or any other qualified Medicare prescription drug plan in any calendar year, prescription drug coverage under this plan will terminate for the remainder of the calendar year. Subsequently, on an annual basis, if you should terminate enrollment in any Medicare Part D prescription drug plan or any other qualified Medicare prescription drug plan, you will be permitted to reinstate your prescription drug coverage under this plan.</td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td></td>
<td></td>
<td>Infertility treatment is not a covered expense for Type C.</td>
</tr>
<tr>
<td>TYPE C MEDICAL BENEFITS</td>
<td>PLAN PAYS</td>
<td>YOU PAY</td>
<td>BENEFIT SUMMARY</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Wellness Benefit (Routine Care)</td>
<td>100%</td>
<td>0%</td>
<td>Only the following routine services are covered for Type C benefits:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Mammogram</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Pap Smear</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- PSA testing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Routine endoscopic surgeries (i.e. colonoscopy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Each type of service is limited to once per calendar year.</td>
</tr>
</tbody>
</table>

Type C benefits are payable at 100% of the remaining balance as shown on your Medicare Explanation of Benefits (EOB) for any service that is a covered expense for Type B. Please note that because a particular type of treatment is covered by Medicare does not mean that same type of treatment will be covered by this plan.

Any service that is covered by Type B that is not covered by Medicare will be payable subject to the Type B PPO benefits.

The plan will reimburse covered expenses at 20% of the otherwise eligible Medicare benefit (both Part A and B). Please refer to page 4-6 for additional information.

Any service that is covered by Medicare but is not covered by Type B will not be a covered expense.
TYPE C – PENSIONER MEDICARE ELIGIBLE BENEFITS EFFECTIVE 10/1/12

The prior authorization requirements beginning on page 1-1 do not apply to participants who have Medicare as their primary coverage. You must call the number on the back of your pharmacy card prior to purchasing any specialty pharmacy medications or benefits will not be payable by the plan.

Please refer to page 4-6 for important information regarding Coordination of Benefits.

A pensioner who returns to employment aboard a vessel, including a return to Covered Employment, without permission from the Board of Trustees of the AMO Pension Plan, will forfeit all eligibility for benefits under the AMO Medical Plan.

<table>
<thead>
<tr>
<th>TYPE C BENEFITS</th>
<th>PAYABLE AT</th>
<th>BENEFIT SUMMARY</th>
<th>TEXT PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part A Expenses</td>
<td>Medicare Approved Amount</td>
<td>For covered expenses received in the United States, benefits are only payable for services received from hospitals and convalescent nursing facilities approved by Medicare. For covered expenses received outside of the United States, the plan will provide benefits for covered expenses if the services would have been covered by Medicare had treatment been received in the United States. The plan will reimburse covered expenses at 20% of the otherwise eligible Medicare benefit (both Part A and B). This plan will include reimbursement of any Medicare Part A deductible.</td>
<td>1-52</td>
</tr>
<tr>
<td>Medicare Part B Expenses</td>
<td>Medicare Approved Amount</td>
<td>This plan will include reimbursement of any Medicare Part B deductible.</td>
<td>1-52</td>
</tr>
<tr>
<td>Prescription Drug Benefits, Including Specialty Pharmacy</td>
<td></td>
<td>Prescription drugs are not payable by the medical plan unless covered by Part A or B of Medicare. Prescription drugs are payable through the EnvisionRx Plus program.</td>
<td></td>
</tr>
<tr>
<td>Vision Coverage</td>
<td></td>
<td>Please refer to the Addendum to the American Maritime Officers Medical Plan Summary Plan Description for additional information.</td>
<td></td>
</tr>
</tbody>
</table>

*You* must always pay all amounts in excess of Medicare Approved Amounts. The plan will not pay any such amounts. ALL PENSIONERS AND THEIR DEPENDENT SPOUSES MUST ENROLL IN BOTH MEDICARE PART A AND PART B AS SOON AS IT IS OFFERED TO YOU. FAILURE TO ENROLL IN BOTH MEDICARE PART A AND PART B COVERAGE WILL RESULT IN BENEFITS NOT BEING PAYABLE BY THE PLAN.
PPO NETWORK INFORMATION

PPO networks negotiate contracts with health care providers to provide services at a discounted price. In return, the provider receives a higher volume of patients due to the plan's incentives to use PPO providers. These contracts establish a fair market value for health care services, which in most cases will reduce your costs.

The plan has contracted with one or more PPO's to provide services to this plan in the areas it has participants. Each PPO network consists of physicians, hospitals and other medical care providers. The PPO that is applicable to you is shown on your ID card.

A directory of providers that are part of your PPO network will automatically be provided to you at no charge. The provider directory is a separate document from this plan. The directory contains the name, address and phone number of the providers that are part of the PPO network.

Any plan limits on access to specialist or emergency care, use of primary care physicians, or pre-authorization of benefits are shown on the Schedule of Benefits.
HOW TO FILE A MEDICAL CLAIM

You will receive a plan identification (ID) card. It will show your name and group number.

PPO provider bills should be sent to the PPO address on your ID card. Non-PPO provider bills can be sent directly to the claims administrator, UMR, Inc., on a standard government claim form. UMR, Inc. does not require special claim forms. You can mail the bills directly to UMR, Inc. if the provider does not forward them. Mail the bills to:

Attention: Claim Department
UMR, Inc.
PO Box 826
Onalaska, WI 54650

Be sure each bill shows the group number and participant number found on your ID card. The participant's name and the patient's name should also be included on each bill. Cash register receipts, canceled checks, money order receipts, statements of account and personal itemization are NOT ACCEPTABLE as itemized bills.

MISCELLANEOUS MEDICAL CHARGES

Bills for medical items you purchased yourself should be sent to UMR, Inc. at least once every three months (quarterly). Make sure each receipt includes: the group number, participant number, participant name, patient name, name of prescribing qualified practitioner and date purchased.

PAYMENT OF CLAIMS

The plan will make direct payment to the service provider. If you have paid the bill, please indicate on the original bill "paid by participant" and payment will be made to you. You will receive a written explanation of payment or reason for denial of any portion of a claim. The plan reserves the right to request any information required to determine benefits or process a claim. You or the service provider will be contacted if additional information is needed to process your claim.

CLAIM FILING LIMITS

You must provide the plan with written proof of your claim. Proof should be provided within 90 days after the date the claim was incurred. Your claim will not be denied if it was not reasonably possible to give such proof. However, unless you were legally incapacitated during the period, any claim received by the plan more than 365 days after the date the claim was incurred will not be covered under the plan.

If the plan is terminated, written proof of any claims incurred prior to the termination must be given to the plan within 90 days of its termination. Any claim received by the plan more than 90 days after it is terminated will not be covered under the plan.
MEDICAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

Deductible
The deductible applies to each covered person, each calendar year. Only charges that are a covered expense will be used to satisfy the deductible. The amount of the deductible is shown on the Schedule of Benefits.

If a participant changes from Type A to Type B in the same calendar year, any deductible amounts satisfied while covered under Type A will be credited toward the deductible amount for Type B and vice versa.

Maximum Family Deductible
The maximum deductible per family is shown on the Schedule of Benefits. No further deductibles will be taken during a calendar year once this maximum has been met.

Coinsurance
The deductible must be satisfied each calendar year. Benefits are then payable at the percentage rate shown on the Schedule of Benefits. Benefits are payable up to any plan maximums on a customary, usual and reasonable basis.

If a participant changes from Type A to Type B in the same calendar year, any coinsurance amounts satisfied while covered under Type A will not be credited toward the coinsurance amount for Type B (as Type B does not have a limit on the coinsurance).

Out-of-Pocket Limit
The amount you must pay is the out-of-pocket limit. The out-of-pocket limit is shown on the Schedule of Benefits. The out-of-pocket limit is made up of the coinsurance (the deductible is in addition to this amount).

If you use PPO and Non-PPO providers, PPO covered expenses will be applied to both out-of-pocket limits.

This limit does not apply to:

1. Penalties for failure to comply with the Prior Authorization Requirements; or

2. Benefit specific copays under the plan.

For Type A, when the out-of-pocket limit has been met for a covered person or family, the plan will pay 100% of covered expenses for the rest of the calendar year. Your out-of-pocket expense for a calendar year will not exceed the Non-PPO limit.

If a participant changes from Type B to Type A in the same calendar year, any coinsurance amounts satisfied while covered under Type B will be credited toward the coinsurance amount for Type A. However, the plan will not reimburse any coinsurance amounts over the Type A out-of-pocket limit that were previously applied while covered by Type B (as Type B does not have an out-of-pocket limit).
PRIOR AUTHORIZATION REQUIREMENTS

HOW THE PROGRAM WORKS
When you call, you will be asked the following questions:

1. Group name and number
2. Name of participant
3. Participant number
4. Name of patient
5. Patient's birthday
6. Patient's address
7. Admitting facility and phone number, if applicable
8. Physician's name and phone number
9. Reason for admission or treatment
10. Admission or treatment date

Once prior authorization is provided, it is valid for 30 days (excluding pregnancies) from the scheduled date of treatment. A new authorization must be made if: you do not receive the treatment within 30 days of the scheduled date; you use a different facility or physician; or you are admitted for a different reason.

PRIOR AUTHORIZATION
You are required to obtain prior authorization before receiving certain types of health care. The services that require prior authorization are listed on the Schedule of Benefits. If you fail to provide prior authorization as required, benefits may be reduced or denied.

PRIOR AUTHORIZATION DOES NOT GUARANTEE BENEFIT PAYMENT. BENEFITS ARE SUBJECT TO ALL PLAN PROVISIONS.

NON-COMPLIANCE PENALTY (FAILURE TO OBTAIN PRIOR AUTHORIZATION)
If you fail to provide prior authorization, your treatment will be reviewed when a claim is received. If it is determined to be a covered expense, benefits that are otherwise payable will be reduced or not covered at all, as shown on the Schedule of Benefits under Non-Compliance Penalty. The penalty may be taken from any charges relating to the treatment. The penalty is taken before subtracting any deductible and coinsurance. The penalty is not applied to the out-of-pocket limit. The first penalty per covered person per lifetime will be waived.

If your treatment is not a covered expense, no benefits will be payable under the plan.

SECONDARY COVERAGE WAIVER
If this plan is secondary to another medical plan that also covers you, prior authorization will not be required.

CASE MANAGEMENT
Case management services help you use your benefits wisely during periods of treatment due to a serious sickness or injury. This is done through early identification of the need for case management, followed by on-going work with you and your provider to plan health care alternatives to meet your needs. The case manager will try to conserve your benefits by making sure that your care is handled as efficiently as possible.

The case management staff consists of licensed, professional nurses. The nurses have years of experience in health care. They know the importance of not intruding in the doctor/patient relationship. By promoting health care alternatives that are acceptable to you and your doctors, case management helps to control health care costs and use your benefits wisely.
DISEASE MANAGEMENT

Disease Management is a proactive approach to better health. The need for services is identified through a screening process. Participation in the program is voluntary. After an initial contact, the patient must agree to continue in the program. The program will then provide ongoing support, education, and coordination of professional and self-care needs for the patient.

All services received through this program are confidential. The program is staffed by experienced, licensed nurses. The nurses are available to address questions you may have regarding your condition. The goal of Disease Management is to assist you in enjoying good health and to prevent future medical complications.

MATERNITY MANAGEMENT

Maternity Management is a prenatal care program that will be offered by the plan effective 6/1/12. It is administered by the licensed professional nurses. The program's goal is to provide valuable wellness benefits to you and your unborn child.

The sole concern of the nurses is your health and the health of your unborn child. They know the importance of not intruding in the doctor/patient relationship. The nurses are here to help you recognize and express your concerns and needs to your qualified practitioner. Some of the services the Maternity Management program offers to you are:

1. Self screening assessments (a survey to help identify if you are at risk of a premature labor);
2. Training in the benefits of early and ongoing prenatal care; and
3. Follow up phone contact from a caring, professional nurse.

You can contact a Maternity Management nurse by calling the toll-free number on your ID card.

By reducing the number of premature births and complicated pregnancies, Maternity Management benefits you, the mother to be, and your unborn child with a healthy beginning together. A beginning that also helps to control costs.
MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL BENEFITS
Charges made for these services furnished during your hospital confinement are payable as shown on the Schedule of Benefits:

1. Room and board charges for: average daily semi-private; ward; intensive care; isolation or coronary care. General nursing services for each day of confinement. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the hospital, unless necessary due to your sickness or injury.

2. Services and supplies provided for the treatment of your sickness or injury, including hospital admission kits. Benefits include services of a radiologist, pathologist and anesthesiologist, when billed directly by the hospital or separately.

QUALIFIED PRACTITIONER BENEFITS
Charges for these services of a qualified practitioner are payable as shown on the Schedule of Benefits:

1. Home and office visits;

2. Inpatient and outpatient hospital visits;

3. Administration of anesthesia;

4. Surgical procedures, including post-operative care.

Benefits are not payable for incidental procedures done during a covered surgery (e.g. the removal of a healthy appendix during abdominal surgery).

Oral Surgery
Charges made for these oral surgeries are payable as shown on the Schedule of Benefits. Benefits include directly related charges for lab tests. Hospital or ambulatory surgical center services are also covered. Any office visit and/or x-rays received prior to your covered oral surgery will be considered under the dental plan and not the medical plan.

1. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;

2. Surgeries required to correct accidental injuries to the jaw, cheeks, lips, tongue, roof and floor of the mouth;

3. Reduction of fractures and dislocations of the jaw;

4. External incision and drainage of cellulitis;

5. Incision of accessory sinuses, salivary glands or ducts.
Oral Surgery – continued

The following oral surgeries will be covered by the plan, if the medically necessary requirements are met:

1. Frenectomy (the cutting of the tissue in the midline of the tongue).
2. Osseous surgery (modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form).
3. Gingivectomy (the excision of diseased gum tissue to eliminate infection).
4. Apicoectomy (the excision of the apex of the tooth root).
5. Alveolectomy (the leveling of the structures support the teeth when performed for reasons other than preparation for dentures).
6. Excision of partially or completely unerupted impacted teeth.
7. Prognathic or orthognathic surgery, including osteotomy.

Dental Injury

Repair of or initial replacement of natural teeth damaged due to injury. Damage resulting from biting or chewing will not be considered an injury.

WELLNESS BENEFIT

Charges for preventive medical services are payable as shown on the Schedule of Benefits. Covered expenses include:

1. Routine physical exams;
2. Routine x-ray and laboratory tests;
3. Routine immunizations;
4. Well child care services as prescribed by a qualified practitioner; and
5. Routine endoscopic surgeries (e.g. colonoscopy).

In addition to the general Limitations and Exclusions of the plan, no benefits are payable under this Wellness Benefit for:

1. Medical examinations for injury or sickness;
2. Medical examinations caused by or related to a pregnancy;
3. Eye examinations for the purpose of prescribing corrective lenses;
4. Hearing tests;
5. Any dental examinations; or
6. Routine exams required for school, sports or camps.
OUTPATIENT HOSPITAL BENEFIT

Charges for these outpatient hospital services are payable as shown on the Schedule of Benefits:

1. Services and supplies provided for the treatment of your sickness or injury;

2. Regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, physical therapy and radiation therapy) when ordered by your attending qualified practitioner; and

3. Emergency room charges, but only if incurred due to:
   a. emergency accident treatment provided within 24 hours of the accident,
   b. a surgical procedure, or
   c. treatment of a sickness that is a medical emergency.

URGENT CARE CENTER BENEFIT

Charges for covered expenses provided by an Urgent Care Center are payable as shown on the Schedule of Benefits.

AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY

Charges made by an ambulatory surgical center for use of the facility in performing a covered surgery are payable as shown on the Schedule of Benefits. Hospital miscellaneous services provided in the facility are also covered.

X-RAY AND LABORATORY TESTS

Charges for diagnostic x-ray and lab tests are payable as shown on the Schedule of Benefits. A qualified practitioner must perform the tests. Tests covered under the Inpatient Hospital Benefit are not covered under this benefit. Dental x-rays are not covered, unless related to a covered injury or oral surgery.

AMBULANCE SERVICE BENEFIT

Charges for ground ambulance service to a local hospital are payable as shown on the Schedule of Benefits. Transfer between hospitals/qualified treatment facilities will be payable if considered medically necessary. If you need care that is not available in a local hospital, transport to the nearest hospital that can provide the care is covered. If you require care that is not available by ground ambulance, air ambulance service to the nearest hospital that can provide the care is covered. Transport from the hospital/qualified treatment facility to your home is not a covered expense, unless approved by the plan prior to receiving the service.

PREGNANCY BENEFIT

Charges for pregnancy are payable as shown on the Schedule of Benefits for any covered female participant or dependent spouse. Complications of pregnancy are payable as a sickness at the point the complication sets in.

In general, Federal law prohibits group health plans and health insurance issuers from limiting benefits for any hospital stay in connection with childbirth to less than 48 hours after a normal vaginal delivery or less than 96 hours after a cesarean section. This law applies equally to the stay of the mother and the stay of the newborn. This law does not generally prohibit the attending provider of the mother or newborn from discharging them, after consulting the mother, at an earlier time than the 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length stay that is not in excess of 48 hours (or 96 hours).
NEWBORN BENEFITS
This benefit does not apply unless you enroll your newborn dependent within 90 days of the date of birth. See the "Eligibility" section of this booklet for more information.

Well-Newborn
Charges for these services for a well-newborn are payable as shown on the Schedule of Benefits: hospital nursery services; circumcision of a male child; routine examination of the newborn child before release from the hospital.

Sick-Newborn
Charges for these services for a sick-newborn are payable as shown on the Schedule of Benefits: treatment of injury or sickness; care and treatment for premature birth; treatment of medically diagnosed birth defects and abnormalities; and surgery to repair or restore normal body functioning. Covered expenses do not include plastic or cosmetic surgery, except surgery for:

1. Reconstruction due to injury, infection or other disease of the involved part; or
2. Congenital disease or anomaly that resulted in a functional defect.

BIRTHING CENTER BENEFIT
Charges made by a birthing center for services and supplies provided for: prenatal care; delivery of children; and immediate postpartum care are payable as shown on the Schedule of Benefits.

CONVALESCENT NURSING HOME BENEFIT
Charges for room and board and nursing care are payable as shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility.

Limitations
Benefits are only payable for a confinement that:

1. Is necessary for care of the same injury or sickness which caused the prior confinement; and
2. Occurs while you are under the care of the qualified practitioner who ordered the confinement.

INPATIENT HOSPITAL REHABILITATION
Expense incurred for daily room and board and rehabilitation or restoration services for each day of confinement in an inpatient hospital rehabilitation center is payable as shown on the Schedule of Benefits.

HOME HEALTH CARE BENEFIT
Charges for Home Health Care, as described below, are payable as shown on the Schedule of Benefits. Benefits will not exceed the customary, usual and reasonable fee for care in a convalescent nursing home.

Each visit to evaluate the need for home health care will be considered one home health care visit. Each visit to develop a plan of home health care will be considered one home health care visit. Each four hour period of home health aide service will be considered one home health care visit. A home health aide visit of four hours or more is considered one visit for every four hours or part thereof.

Home Health Care will not be covered unless a qualified practitioner certifies that:

1. Confinement in a hospital or convalescent nursing home would be required without the home care;
Home Health Care – continued

2. Necessary care is not available from your family members or other persons residing with you, without causing undue hardship;

3. The home health care services will be provided or coordinated by a state-licensed or Medicare-certified home health care agency or certified rehabilitation agency.

If you were in a hospital prior to starting home health care, the home health care plan must also be approved by the primary provider of services during your hospital stay.

A home health care plan may consist of:

1. Part-time home nursing care by or under the supervision of a registered nurse (R.N.);

2. Part-time home health aide services provided under the supervision of a registered nurse (R.N.) or medical social worker. Services must consist solely of caring for the patient;

3. Physical, respiratory, occupational or speech therapy;

4. Medical supplies and drugs prescribed by a qualified practitioner. Lab tests by or on behalf of a hospital, when necessary under the home care plan;

5. Nutritional counseling provided under the supervision of a registered or State certified dietician, when such services are necessary as part of the home care plan; and

6. An evaluation of home health care needs. The development of a home health care plan. This service may be done by an R.N., physician assistant or medical social worker.

HOSPICE CARE BENEFIT

Charges for these hospice care services are payable as shown on the Schedule of Benefits. Hospice care must be in lieu of a covered hospital or convalescent nursing home confinement.

1. Room and board;

2. Part-time nursing care by or supervised by a registered nurse (R.N.);

3. Counseling by a licensed clinical social worker. Benefits are provided for the hospice patient and immediate family;

4. Medical social services provided to you or your immediate family. Services include:
   a. assessment of social, emotional and medical needs, and the home and family situation, and
   b. identification of the community resources available and assisting in obtaining those resources;

5. Dietary counseling;

6. Consultation and case management services;

7. Physical or occupational therapy;

8. Part-time home health aide service; and

9. Medical supplies, drugs and medicines prescribed by a qualified practitioner.

Revised 1/1/12

1-46
Limitations

Hospice care must be furnished in a hospice facility or by a hospice care agency in your home. A qualified practitioner must certify that you are terminally ill with a life expectancy of six months or less (if the patient lives longer than six months, charges will not be denied). For hospice care only, your immediate family is your parent, spouse and dependent children.

Hospice care benefits do not include: private or special nursing services; a confinement not required for pain control or other acute chronic symptom management; funeral arrangements; or financial or legal counseling including estate planning or drafting of a will.

Hospice care benefits do not include homemaker or caretaker services; sitter or companion services; house cleaning or household maintenance; services by volunteers or persons who do not regularly charge for their services; services by a licensed pastoral counselor to a member of his congregation; or bereavement counseling.
PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT

Inpatient and Transitional Treatment Benefits
Charges for inpatient treatment are payable as shown on the Schedule of Benefits. Charges for a transitional treatment program are payable as shown on the Schedule of Benefits.

Transitional treatment means treatment that is provided in a less restrictive manner than inpatient treatment, but in a more intensive manner than outpatient treatment.

Transitional treatment includes the following services or programs when approved by the Department of Health and Social Services: adult day treatment programs; child and adolescent day treatment programs; services for the chronically psychologically ill provided by a community support program; services provided by a residential treatment program; and services provided in a day treatment program. Transitional treatment also includes services in intensive outpatient programs provided in accordance with the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine.

Outpatient Benefits
Charges for outpatient treatment are payable as shown on the Schedule of Benefits. Outpatient Benefits include related expenses for diagnostic lab tests and psychological testing. Prescription drugs are payable under the Prescription Drug Benefit.

Limitations
Benefits do not include: 1. Treatment of being overweight or obese; 2. Marriage counseling; or 3. Court ordered examinations or counseling, for which the participant is not otherwise eligible and/or the maximum benefit has not been met.

Covered expenses are applied to the out-of-pocket limit shown on the Schedule of Benefits.
OTHER COVERED EXPENSES

These other covered expenses are payable as shown on the Schedule of Benefits:

1. Blood and blood plasma that is not replaced by donation. Blood and blood products including blood extracts or derivatives.

2. Prosthetic devices to replace lost natural limbs and eyes. Replacement devices and repair expenses are a covered expense, however, maintenance expenses are not covered.

3. Special supplies when prescribed by your attending qualified practitioner and necessary for the continuing treatment of a sickness or injury:
   
   a. catheters,  
   b. colostomy bags, belts and rings,  
   c. flotation pads,  
   d. casts, splints, surgical dressings, trusses, braces and crutches,  
   e. oxygen and other gases,  
   f. initial contact lenses or eyeglasses for the treatment of keratoconus or following cataract surgery.

4. Mechanical medical devices placed in the body to aid the function of a body organ (e.g. pacemaker, artificial larynx, artificial hip).

5. Custom molded orthotic devices. Please note that custom molded orthotics require a prescription from your qualified practitioner.

6. Rental of durable medical equipment or purchase of such equipment when approved by the plan (e.g. wheelchair, hospital bed). The equipment must be needed for therapeutic treatment and not be mainly hygienic, custodial or educational in nature. It must be able to withstand repeated use. It must be primarily and normally used to serve a medical purpose. It must not be generally useful to a person except for the treatment of an injury or sickness. Repair expenses are not covered, unless the equipment has been purchased. Maintenance expenses are not covered. Convenience items, as determined by the plan, are not covered. Unless approved by the plan, benefits for the rental of durable medical equipment will not exceed the cost to purchase the item.

7. Chiropractic care for the treatment of an injury or sickness. Routine or maintenance chiropractic care is a covered expense.


9. Elective sterilization, vasectomy and tubal ligation. Covered for participants and dependent spouses only.

10. Treatment by a licensed: physical therapist; speech therapist; occupational therapist or outpatient cardiac rehabilitation therapist. All treatment must be to restore loss or correct impairment due to an injury or sickness.

11. Treatment by a licensed respiratory therapist. Treatment must be to restore loss or correct impairment due to an injury or sickness.

12. Radiation therapy and chemotherapy. Benefits will be payable as any other sickness or injury.
Other Covered Expenses – continued

13. Acupuncture, when received from a qualified practitioner.

14. Pre-admission testing, when received within three days of your surgery.

15. For Type A, B and C, tissue transplants (e.g. arteries or veins, corneas, heart valves, skin) placed in the body to aid the function of a body organ or replace tissue lost due to sickness or injury.

16. For Type A only, the following human organ transplants (other transplants are not a covered expense). The transplant must be provided from a human donor to a living human recipient:
   a. kidney transplants;
   b. liver transplants; and
   c. autologous bone marrow/stem cell transplants.

   If a Transplant Network Facility is used, the plan will cover the following additional expenses for Type A only:

   1. travel expense for the covered person and one member (two if the patient is a minor child) of their immediate family. Only travel to accompany the covered person to and from the Transplant Facility is covered; and
   2. lodging at or near the Transplant Facility for the family member(s) who accompanied the covered person. Lodging is only covered while the covered person is confined at the Transplant Facility.

   Benefits for travel expense and lodging are limited to a combined maximum for the recipient and donor of $10,000 paid per transplant. Further information on the Transplant Network will be provided to you as part of the prior authorization process for a transplant procedure.

   Donor expenses are only covered by this plan when the recipient is a Type A participant. The donor's benefits are limited to those not available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any government program. Benefits for the donor are charged against the recipient's coverage under the plan.

   When only the donor is covered by the plan, the donor is not entitled to benefits.

   If any organ or tissue is sold rather than donated, no benefits are payable for the purchase or removal of such organ or tissue. Other costs related to the evaluation and procurement are covered for a recipient who is covered under this plan.

17. When reconstructive surgery is elected after a mastectomy, the following services will also be covered:

   a. reconstruction of the breast that was removed,
   b. surgery and reconstruction of the other breast to produce a symmetrical appearance,
   c. prostheses to replace the breast that was removed, and
   d. any physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

   Benefits must have been payable for the mastectomy and these services must be part of the ongoing treatment of that mastectomy to be covered under the plan. Covered expenses will be payable as any other sickness or injury.
Other Covered Expenses – continued

18. Surgical and non-surgical treatment of any jaw joint problem, including but not limited to appliances and therapy. Jaw joint problems include: temporomandibular joint disorder (TMJ); craniomaxillary or craniomandibular disorders; other conditions of the joint linking the jawbone and skull; conditions of the facial muscles used in expression or mastication; and symptoms thereof including headaches. Covered expenses do not include orthodontic services or treatment.

19. Treatment of infertility, subject to the maximum shown on the Schedule of Benefits. Only services with a confirmed infertility diagnosis are applied to the maximum. Any testing prior to the determination of the infertility diagnosis does not apply to the maximum. Treatment includes but is not limited to artificial means to achieve pregnancy such as in vitro fertilization, GIFT, ZIFT, artificial insemination. Prescription drugs will be payable through the Prescription Drug Card and will be applied to the infertility lifetime maximum as stated on the Schedule of Benefits.

20. Routine hearing exams and hearing aids, payable as stated on the Schedule of Benefits. Covered expenses do not include hearing aid batteries. Please note this benefit is only available to participants (and their covered dependents) eligible for Type A.

21. Nicotine addiction treatment, including qualified practitioner office visits and any related x-ray or lab tests, prescription and over-the-counter drugs and counseling. Over-the-counter drugs are reimbursed through the medical plan. Prescription drugs will be reimbursed through the Prescription Drug Card.

22. For covered participants and dependent spouses only, birth control implants, injections and devices. Benefits include any related qualified practitioner charges. Other forms of birth control may be available through the Prescription Drug Card. Benefits will be payable as any other sickness or injury.

23. Eye refractive surgery.
Services Covered By Medicare
The plan will continue to cover the Part A and Part B deductible and coinsurance amounts even if they are changed by Medicare. If Medicare changes deductible and coinsurance amounts, the benefits designed to cover these cost sharing amounts will automatically be changed.

Services Covered By Medicare
Medicare Part A assists you with expenses for hospital services, services provided by a skilled nursing facility, home health care, services provided by a hospice facility and durable medical equipment.

Medicare Part B assists you with expenses for qualified practitioner home and office visits, home health care, physical therapy, speech pathology, outpatient hospital services, x-rays, lab tests, ambulance services and durable medical equipment.

When all of the provisions of this plan are satisfied, the plan will provide benefits as outlined on the Schedule of Benefits. Total benefits for any covered service payable under Medicare and this plan will not exceed the Medicare approved amount for that service.

Please note that any expenses not covered by Medicare, will not be covered by this plan.
LIMITATIONS AND EXCLUSIONS

This plan does not provide benefits for:

ALTERNATIVE TREATMENTS

1. Acupuncture, except as specifically stated otherwise;

2. Any treatment or services relating to chelation therapy, except in the treatment of heavy metal poisoning; or

3. Any charge for alternative medical treatments. Treatments include but are not limited to: holistic medicine, ayurveda and ayurvedic nutrition, craniosacral therapy, yoga, homeopathy, movement therapy, tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, rolfing, reiki, reflexology, therapeutic touch, colon therapy, herbal therapy, vitamin therapy, and hypnotherapy. Please note that any of the above will be covered if received for the treatment of nicotine addiction.

DENTAL

1. Dental care or treatment to the teeth, nerves and roots of the teeth, gums or other gingival tissues, or the supporting structures of the teeth (alveolar processes), except as stated; or

2. Dental implants.

DRUGS

1. Birth control biologicals and patches are not covered under the medical benefit. Some forms of birth control may be available for participants and dependent spouses through the Prescription Drug Card. Please note, effective 5/1/12, oral contraceptives will be covered for eligible dependent children through the Prescription Drug Card;

2. Medications for impotence, anorexiants, vitamins (all types of vitamins with or without prescription), medications and supplies that are available over the counter, and food supplements. Pre-natal vitamins may be available for participants and dependent spouses through the Prescription Drug Card; or

3. Charges for prescription drugs, except when not covered by the plan’s Prescription Drug Card and not excluded under any other provision of this plan.

EXPERIMENTAL OR UNPROVEN SERVICES

1. Experimental, investigational or unproven services, which means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

   a. items within the research, investigational or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
**Limitations and Exclusions - continued**

b. items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

c. items based on anecdotal and unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

d. items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered experimental, investigational or unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

**PHYSICAL APPEARANCE**

1. **Plastic or cosmetic surgery**, including any services or supplies related to, resulting from complications of or for reversal of cosmetic surgery. Reconstructive surgery due to injury, infection or other disease of the involved part is a covered expense when the need for such surgery is not the result of or a complication of a prior cosmetic procedure;

2. Any treatment or services for **weight control or reduction**. Treatment includes, but is not limited to: nutritional supplements; dietary or nutritional counseling; individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs;

3. Any treatment of **obesity or morbid obesity**, including, but not limited to surgery (e.g. stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy), except in the case of an active sailing participant who meets the medically necessary criteria for bariatric surgery as established by the plan and who is also in jeopardy of falling outside of USCG requirements (please call the plan for additional information); or

4. **Transsexual surgery**, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
PROVIDERS
1. Any service or supply:
   a. provided while you are not under the regular care of a qualified practitioner,
   b. not authorized or prescribed by a qualified practitioner,
   c. authorized or prescribed by a qualified practitioner, but excluded under this plan;
2. 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;
3. Telephone, computer or Internet consultations between you and any provider. Completion of claim forms or forms necessary for your return to work or school. Any appointment you did not attend; or
4. Private duty nursing.

REPRODUCTION
1. Elective abortions performed by any means including surgical and pharmaceutical methods;
2. Treatment, services or supplies for a surrogate mother or any pregnancy resulting from your service as a surrogate mother;
3. Treatment of a sexual dysfunction, including, but not limited to sexual counseling or therapy, implants and hormonal therapy;
4. Genetic testing or counseling unless medically necessary to determine the course of treatment for a sickness, or for confirming family history and/or other guidelines approved by the National Institute of Health. Approved genetic testing must be appropriate for the specific patient’s diagnosis or documented risk of sickness under the guidelines. Genetic testing which is determined to be experimental or investigational is not covered by the plan;
5. Reversal of male and female voluntary sterilization procedures; or
6. Pregnancy charges for anyone other than the participant or dependent spouse.

SERVICES UNDER ANOTHER PLAN
1. Any charges incurred by a covered participant or dependent as a result of:
   a. an accidental bodily injury arising out of or in the course of employment for pay, profit or gain; or
   b. a sickness or injury for which you are entitled to a benefit under any workers’ compensation law or the Jones Act, or other maritime industry or common law; or
   c. in the case of Deep Sea, Inland Water and Great Lakes participant, any sickness or injury (including dental) occurring on a vessel;
   d. in the case of Deep Sea, Inland Water and Great Lakes participants, the above will be waived for the first $10,000 of covered expenses per occupational injury or sickness (including dental) occurring aboard a vessel;
   e. in the case of Deep Sea, Inland Water and Great Lakes participants, for services provided for the treatment of a sickness (not injury) 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 for the treatment of the sickness in accordance with the Rules governing pensioner medical benefits;

Revised 1/1/12
Limitations and Exclusions – continued

2. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this agreement;

3. Any charges that would have been paid by your primary plan had you complied with all of the pre-certification or pre-notification requirements of that plan;

4. 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 Veteran’s Hospital, or elsewhere at Federal Government expense, unless required by law; or

5. Any service or supply provided in the care of any service related injury or sickness (past or present) if you are in a hospital or facility owned or operated by the United States Government or any of its agencies.

OTHER

1. Charges in excess of the customary, usual and reasonable charge for the service or supply;

2. Services not medically necessary for diagnosis and treatment of an injury or sickness;

3. Expense incurred in connection with sickness or injury resulting from declared or undeclared war;

4. Any medical expense due to commission or attempt to commit a civil or criminal battery or felony;

5. Services performed by a massage therapist;

6. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses or eyeglasses for the treatment of keratoconus or post cataract surgery);

7. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy;

8. Educational testing or training (except initial diabetes training);

9. Prognathic or orthognathic surgery, including related osteotomy, except as specifically stated otherwise in this plan for dependent children;

10. Macromastia, gynecomastia, varicose veins, rhinoplasty, unless treatment meets this plan’s definition of medically necessary;

11. Prophylactic surgery to prevent a sickness that has not occurred yet;

12. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic or custodial evaluations;

13. Non-medical counseling or ancillary services, including, but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy;

Revised 1/1/12
Limitations and Exclusions – continued

14. AIDS or devices that assist with **non-verbal communications**, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, personal digital assistants, Braille typewriters, visual alert systems for the deaf and memory books, except as specifically stated otherwise;

15. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other **custodial services** or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care;

16. **Routine foot care**, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when treatment meets this plan’s definition of medically necessary;

17. Cost of biologicals (and any related administration expenses) that are immunizations or medications for the purpose of **travel**, or to protect against occupational hazards and risks;

18. Routine hearing examinations or hearing aids, except as specifically stated otherwise;

19. Any human organ or tissue transplant except as stated. Any **non-human organ transplant**. Any artificial organ transplant;

20. Any treatment that is provided to enhance the life style of a person **without treating** a **sickness or injury**; or

21. Any service or supply provided in connection with or as a result of any service or supply that is not a **covered expense**.
PRESCRIPTION DRUG CARD

A directory of participating pharmacies is available on the Drug Card’s web site. You will also be automatically provided a copy of the pharmacy directory at no charge. The pharmacy directory is a separate document from this plan. The directory contains the name, address and phone number of the pharmacies that are part of the Drug Card.

Covered Drugs

Your Drug Card provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, “Caution: Federal law prohibits dispensing without a prescription.” Your pharmacist or the prescribing physician can verify coverage for a drug by contacting the Drug Card service at the number on your ID card. A complete list of covered and excluded drugs is available on the Drug Card’s web site. If you are unable to access the Drug Card’s web site, the plan will provide a copy upon request at no charge.

How To Use The Prescription Drug Card

Present the ID Card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the copay shown on the Schedule of Benefits.

If you are without your ID Card or at a non-participating pharmacy, you may be required to pay for the prescription and submit a claim to the Drug Card service. Claim forms are available from the plan.
SECTION 2  DEFINITIONS
DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used in the plan. Defined words appear in italic throughout the plan.

**Accident**
A happening by chance and without intention or design. A happening, which is unforeseen, unexpected and unusual at the time it occurs.

**Ambulatory Surgical Center**
A distinct facility whose business purpose is to provide surgical services on an outpatient basis. The facility must be duly licensed by the state in which it is located. It may not provide accommodations for patients to stay over night.

**Amendment**
A written document that changes the provisions of the plan. It must be duly authorized and signed by the plan administrator.

**Birthing Center**
A licensed facility which: 1. Provides prenatal care, delivery and immediate postpartum care, and care of a child born at the birthing center; 2. Is directed by a qualified practitioner specializing in obstetrics and gynecology; 3. Has a qualified practitioner or certified nurse midwife present at all births and during the immediate postpartum period; 4. Extends staff privileges to qualified practitioners who practice obstetrics and gynecology in the area; 5. Has at least two beds or birthing rooms for use by patients during labor and delivery; 6. Provides full-time skilled nursing services (directed by a R.N. or certified nurse midwife) in the delivery and recovery rooms; 7. Provides diagnostic x-ray and laboratory services for the mother and newborn; 8. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear); 9. Is equipped and staffed to handle medical emergencies and provide immediate life support measures; 10. Accepts only patients with low risk pregnancies; 11. Has a written agreement with an area hospital for emergency transfer of patients and ensures its staff is aware of the procedure; 12. Provides an ongoing quality assurance program; and 13. Keeps a medical record for each patient.

**Calendar Year**
A 12 month period of time that starts on January 1 and ends on December 31.

**Claims Administrator**
The person or firm employed by the plan administrator to provide clerical services to the plan. Clerical services include the processing of claims. If a claims administrator is not employed by the plan administrator, claims administrator will mean the Board of Trustees of the AMO Medical Plan.

**Complications of Pregnancy**
1. Medical conditions that are distinct from pregnancy, but adversely affected by pregnancy or caused by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;

2. A non-elective cesarean section surgical procedure;

3. A terminated ectopic pregnancy; or

4. A spontaneous termination of pregnancy that occurs during a gestation in which a viable birth is not possible.
Definition of Complication of Pregnancy - continued

Complications of pregnancy does not mean: false labor; occasional spotting; prescribed rest during the pregnancy; or similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct medical diagnosis.

Confinement
Being a resident patient in a hospital for at least 18 consecutive hours per day. Being a resident bed patient in a convalescent nursing home or other qualified treatment facility 24 hours a day. Successive confinements are considered one if:

1. Due to the same injury or sickness; and
2. Separated by fewer than 60 consecutive days when you are not confined.

Convalescent Nursing Home (Skilled Nursing Facility or Extended Care Facility)
A facility, or distinct part thereof, that is duly licensed where it is located. It must maintain and provide:

1. Full-time bed care facilities for resident patients;
2. A qualified practitioner's services available at all times;
3. A registered nurse (R.N.) or qualified practitioner in charge and on full-time duty. With one or more registered nurses (R.N.'s) or licensed vocational or practical nurses on full-time duty;
4. A daily record for each patient; and
5. Continuous skilled nursing care during convalescence from sickness or injury.

A convalescent nursing home is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Covered Expense
Expense not excluded by the plan that is incurred by you or your covered dependents due to an injury or sickness. Expenses must be incurred while you are covered for that benefit under this plan.

Covered Person
The participant or any dependent, when you are properly enrolled in the plan.

Custodial Care
Care to assist in the activities of daily living. Care that is not likely to improve your sickness or injury.

Customary, Usual and Reasonable
For Non-PPO Providers, the lesser of the fee most often charged by the provider or the maximum allowable fee as determined by the plan. The maximum allowable fee is set by comparing the service to a national database of fees. The database is adjusted to the locality where the service was performed.

1. If more than one surgery is performed during an operative session, the covered expense will be limited. The customary, usual and reasonable (CU&R) fee for the primary surgical procedure will be payable. 50% of the CU&R fee for the secondary procedure will be payable. 50% of the CU&R fee for the third and following procedures will be payable.
2. The CU&R fee for an assistant surgeon or physician's assistant is based on the CU&R fee for the primary surgeon as follows: 16% for an assistant surgeon; and 14% for a physician's assistant.

Revised 1/1/12
Definition of Customary, Usual and Reasonable - continued

In the case of a PPO Provider, it will mean the negotiated PPO discount rate for the service or procedure.

Dependent

1. A covered participant's lawful spouse, as defined in the State where you reside, provided that the spouse is not legally separated from the participant.

2. A covered participant's married or unmarried: natural born, blood related child; step-child; legally adopted child; child placed in the participant's legal guardianship by court order; or a child placed with the participant for the purpose of adoption and for which the participant has a legal obligation to provide full or partial support; whose age is less than the limiting age.

The limiting age for each dependent child is:

a. for dependent children who do not have access to coverage through their own employer, 26 years of age;

b. for dependent children who are working and eligible for benefits through their own employer, 19 years of age. If however, your dependent child is in regular full-time attendance, as determined by the school, at a State recognized high school or an accredited college, university or other institution of higher education as defined by Federal law (20 USC 1088), coverage will be extended to the earlier of the expected graduation date or age 26. 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 definition, full-time shall mean the completion of 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.

Right To Check Dependent Eligibility

The plan reserves the right to check the eligibility status of a dependent at any time during the year. You and your dependent have an obligation to notify the plan when the dependent’s eligibility status changes during the year. Please notify the plan of any status changes.

If, from the date a dependent child reaches a limiting age, all of the following conditions exist at the same time:

1. The child is totally disabled as defined by the Social Security Administration;

2. The child is incapable of self-sustaining employment;

3. The child is dependent on the covered participant for principal support and maintenance; and

4. The child is unmarried,

that child will remain an eligible dependent of a covered participant or may be enrolled as the dependent of a new participant. If the child has not continuously satisfied all of the conditions above since reaching a limiting age, the child will not be eligible for coverage under the plan.

You must provide satisfactory proof that the above conditions exist on and after the date the limiting age is reached. Such proof may not be requested more often than annually after two years from the date the first proof was provided. If satisfactory proof is not submitted, the child's coverage will cease on the date such proof is due.

If both parents are eligible for coverage under this plan, each may enroll for dependent coverage.
Definitions – continued

Emergency
Any injury or sickness that would jeopardize or impair the health of the covered person if not treated immediately. An emergency may or may not be life threatening. A condition is considered to be an emergency care situation when a sudden and serious condition such that a prudent layperson could expect the patient’s life would be jeopardized, the patient would suffer severe pain, or serious impairment of bodily functions would result unless immediate medical care is rendered. Examples of an emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103°F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

Enrollment Date
The first day of your eligibility period or if earlier, your effective date of coverage under this plan.

Essential Health Benefits
Any covered expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care, etc.

Expense Incurred
For medical expenses, the customary, usual and reasonable fee charged for services and supplies needed to treat the injury or sickness. The date a supply or service is provided is the expense incurred date.

Family Member

Home Health Care Agency
An agency or organization that specializes in providing medical care in the home. Such a provider must meet all of the following conditions:

1. Its primary purpose is to provide skilled nursing and other medical services. Is duly licensed in the location where services are provided;

2. Has policies set by a professional group. This professional group must have at least one registered nurse (R.N.) to govern the services provided. It must provide for full-time supervision of such services by a qualified practitioner or registered nurse;

3. Maintains a complete medical record on each patient;

4. Has a full-time administrator; and

5. Is approved by Medicare.

Hospice Care Agency
An agency whose primary purpose is providing hospice services. It must be licensed and operated according to the laws of the state in which it is located. It must meet all of the following requirements: has obtained any required certificate of need; provides 24 hour a day, seven day a week service; is supervised by a qualified practitioner; has a full-time coordinator; keeps written records of services provided to each patient; has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and has a licensed social service coordinator.
**Definition of Hospice Care Agency – continued**

A *hospice care agency* will establish policies for the provision of *hospice care*. It will assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program. It will permit area medical personnel to use its services for their patients. It will use volunteers trained in care of and services for non-medical needs.

**Hospice Care**

Palliative and supportive care to hospice patients. It offers supportive care to the families of the hospice patients. It offers an assessment of the hospice patient's medical and social needs and a description of the care necessary to meet those needs. *Hospice care* must be provided under a written plan of *hospice care*. The plan must be established and reviewed by the *qualified practitioner* attending the person and the *hospice care agency*.

**Hospice Facility**

A licensed facility or part thereof that principally provides *hospice care*. It has 24 hour a day nursing services provided under the direction of a registered nurse (R.N.). It has a full-time administrator. It keeps medical records of each patient. It has an ongoing quality assurance program, and has a *qualified practitioner* on call at all times.

**Hospital**

A facility that:

1. Maintains full-time facilities for bed care of resident patients;
2. Has a *qualified practitioner* and surgeon in regular attendance;
3. Provides continuous 24 hour a day nursing services;
4. Primarily provides diagnostic and treatment facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical services with a facility having a valid license to provide such surgical services.

*Hospital* does *not* include an institution, which is principally a rest home, nursing home, convalescent home or a home for the aged. *Hospital* does *not* include a place principally for alcoholics, drug addicts or persons with psychological disorders.

**Injury**

Physical damage to *your* body caused by an external force. Damage must be due directly and independently of all other causes to an *accident*. Muscle tiredness or soreness is a *sickness* under the plan. Overexertion in an athletic or physical activity is a *sickness* under the plan.

**Lifetime**

When used in reference to benefit maximums and limitations, the time *you* are covered under this plan. In no circumstances does *lifetime* mean *your* life span.

**Medical Condition**

A syndrome or group of symptoms that are not attributable to a specific disease or a distinct medical diagnosis.
**Definition of Medically Necessary – continued**

**Medically Necessary**
Means health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms, that are all of the following, as determined by the plan or our designee, within our sole discretion:

1. In accordance with Generally Accepted Standards of Medical Practice; and

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms; and

3. Not mainly for your convenience or that of your qualified practitioner; and

4. Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury or symptoms.

The fact that a physician or qualified practitioner has performed, prescribed, recommended, ordered or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility medically necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to you by calling UMR, Inc. at the telephone number shown on your ID card, and to qualified practitioners, physicians and other health care professionals on UnitedHealthcareOnline.com.

**Medicare**
Title XVIII, Parts A and B, of the Social Security Act as enacted and amended.

**Named Fiduciary**
Board of Trustees of the AMO Medical Plan, which has the authority to control and manage the operation of the plan.

**Non-Essential Health Benefits**
Any covered expense that is not an essential health benefit. Please refer to the essential health benefits definition.
Definitions - continued

**Outpatient**
A period of time during which you are not confined as a resident bed patient in a: hospital; convalescent nursing home; or other qualified treatment facility.

**PPO**
Preferred Provider Organization. If a provider has contracted with the PPO Network, they are a PPO Provider. PPO providers furnish services at a discounted rate to the plan. If a provider has not contracted with the PPO Network, they are a Non-PPO provider.

**Participant**
You, when you establish eligibility as stated in the AMO Medical Plan Rules and Regulations, which is contained in a separate document. For purposes of this plan, participant does not include independent contractors or leased employees.

**Participating Employer**
An employer who is signatory to the American Maritime Officers (AMO) Medical Plan.

**Pensioner**
The term pensioner means a former employee receiving a pension from the AMO Pension Plan or from an Inland Water Company Pension Plan and who at the time of retirement (and at the time an in-service lump sum distribution was received, if applicable) was employed by a company obligated to make contribution 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 Termination of Coverage section). 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.

**Plan**
This plan of benefits as established by the Board of Trustees. The term plan includes any schedules, attachments and amendments to the plan. Prior, current and successive plans will be considered one plan and not separate and distinct plans. This Summary Plan Description provides a description of the plan.

**Plan Administrator**
The Board of Trustees, who is responsible for the day to day functions and engagement of the plan. The Board of Trustees may employ other persons or firms to process claims and perform other services.

**Post-Service Claim**
Any claim that is not a pre-service claim.

**Pre-Service Claim**
Any claim for a benefit that is conditioned, in whole or in part, on obtaining prior approval from the plan for the medical care.
Definitions - continued

Prior Authorization
The process of determining benefit coverage prior to service being rendered to a covered person. A determination is made based on medical necessity (medically necessary) criteria for services, tests or procedures that are appropriate and cost-effective for the covered person. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Prudent Layperson
A person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Qualified Practitioner
A licensed practitioner providing services within the scope of that license. A qualified practitioner's services are not covered if the practitioner resides in your home or is a family member.

Qualified Treatment Facility
A facility that is duly licensed and operating within the scope of its license.

Sickness
A disease or disturbance in function or structure of your body. It must cause physical signs and/or symptoms and if left untreated, will result in a deterioration of the health state of the structure or systems of your body.

Specialty Drug
All drug programs, drug treatment and drug therapies costing $500 or more and associated with a chronic or critical sickness including but not limited to chemotherapy, IV infusion therapies and treatment of hepatitis-C and HIV.

Urgent Care
Any care that in the opinion of your qualified practitioner is an urgent care situation. Any care that the use of non-urgent care time frames would put your life, health or ability to regain maximum function at risk.

Urgent Care Center (Walk-In Clinic)
A facility that provides outpatient medical care on a walk-in or unscheduled basis. Such care may be offered during extended hours that include evenings, weekends and holidays. Urgent Care Center does not include a hospital or emergency room.

You and Your
You as the covered participant. Any of your dependents, unless otherwise indicated.
ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

The Participant Coverage section applies to participants hired on or after the effective date of this plan. The Dependent Coverage section applies to dependents that are added on or after the effective date of this plan.

Participants who were covered under any plan that this plan replaces will be covered on the effective date of this plan. Coverage will include dependents of such a participant. You must have met the eligibility requirements of the plan.

PARTICIPANT COVERAGE

Participant Eligibility
A participant establishes initial eligibility for benefits on the day following 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 day following the date he or she completes thirty 30 days of covered employment within a period of 182 consecutive days. Please note: Eligibility for Administrative, Union and certain other employees is established on the date the participant completes 90 days of covered employment.

Covered Employment
Covered employment includes the following:

1. Days of actual employment with companies signatory to the AMO Medical Plan;

2. Days of paid vacation from the AMO Vacation Plan when taken provided 30 or more days of actual shipboard employment are completed within the immediately preceding six consecutive months, unless as provided in item 7 of this section;

3. Days the participant receives unearned wages from a Deep Sea company and for which the company makes contributions to this plan;

4. Days of disability for which the participant receives Disability Benefits (Accident and Sickness Benefits) from this plan;

5. Days of participation as an observer under the Observer Training Program sponsored by the American Maritime Officers Safety and Education Plan;

6. 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;

7. Days of family leave for Great Lakes employment under an AMO contract which provides family leave and under which the company makes family leave 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:

1. 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;

2. Administrative, Union, and certain other participants remain eligible for 30 days following their last date of covered employment (or as otherwise provided in the applicable Collective Bargaining Agreement);

3. 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.

Coverage will begin at 12:01 AM, Standard Time, on your effective date.

DEPENDENT COVERAGE

Dependent Eligibility
A dependent is eligible to be covered on the later of:

1. The date the participant is covered;

2. The date of the participant's marriage for a dependent acquired on that date;

3. The child's date of birth;

4. The date a court order places a child in the participant's home. The child must be under the participant's legal guardianship;

5. The date a child is legally adopted; or

6. The date a valid court order is issued which, by federal law or plan provision, requires the plan to provide coverage.

Dependents may only be covered if the participant is covered. Check with the plan on how to enroll for dependent coverage. When both parents are participants, each may enroll for dependent coverage.

Dependent Effective Date
Each dependent's effective date of coverage is determined by the plan administrator: Coverage will begin at 12:01 AM, Standard Time, on the dependent's effective date.

A dependent child that becomes a participant must apply for coverage as a participant to remain covered by the plan. The dependent child will no longer continue to be eligible as your dependent.

PENSIONER COVERAGE

You will be eligible for pensioner coverage if you meet the eligibility requirements as defined in the AMO Medical Plan Rules and Regulations, which are contained in a separate document. If you meet the requirements, coverage will include any of your eligible dependents.

NOTE: If you are Medicare eligible, you must have both Part A and Part B Medicare coverage. Claims must be submitted to Medicare first. After Medicare has processed your claim, the claim and the Medicare EOB should be submitted to this plan.
BENEFIT CHANGES

Any change in benefits will be effective on the date of change for all participants and dependents. Any change in coverage will be effective on the date of change for all participants and dependents.

SURVIVORSHIP CONTINUATION

In the event a pensioner receiving Pensioner Benefits predeceases his dependent spouse, the surviving eligible dependent spouse and any eligible dependent children will continue to qualify for medical benefits, provided the surviving dependent spouse is receiving a Survivor’s Pension Benefit under the AMO Pension Plan, or benefits were paid under the Lump Sum Option. A spouse is considered a surviving eligible dependent spouse only if the pensioner and spouse were married on the Pension Effective Date.

If the 60-month payout is in effect, the surviving dependent spouse and eligible dependent children will be entitled to medical coverage only for the remaining period of such 60-month payout.

If the 60-month payout is not in effect, coverage will continue until the date of the dependent spouse’s death or until dependent children no longer meet this plan’s definition of dependent.

The Board of Trustees reserve the right to amend, modify or terminate, in whole or in part, survivor benefits. At the end of this period, COBRA Continuation will be offered to any eligible dependents.
TERMINATION OF COVERAGE
Coverage terminates on the earliest of the following:

1. The date the plan terminates;
2. For any benefit, the date the benefit is removed from the plan;
3. The end of the period for which any required contribution was due and not paid;
4. The date you enter the full-time military, naval or air service of any country;
5. The date in which you fail to be in an eligible class of persons according to the eligibility requirements of AMO Medical Plan Rules and Regulations;
6. For all participants, the date of your retirement, unless you are eligible for Pensioner Coverage;
7. For your dependents, the date your coverage terminates;
8. For a dependent, the date the dependent enters the full-time military, naval or air service of any country;
9. For a dependent, the date that dependent no longer meets this plan's definition of dependent;
10. The date you request termination of coverage to be effective for yourself and/or your dependents; or
11. The date you die.

Rescission of Coverage
As permitted by the Patient Protection and Affordable Care Act, the plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is not a rescission if:

1. It has only a prospective effect; or
2. It is attributable to non-payment of premiums or contributions.

Important Notice for Active Participants and Spouses Age 65 and Over
The plan cannot terminate your coverage due to age or Medicare status. An active participant that is eligible for Medicare due to age (age 65 or over) has the choice to:

1. Maintain coverage under this plan, in which case Medicare benefits would be secondary to this plan; or
2. End coverage under this plan, in which case Medicare would be the only coverage available to you.

An active participant's spouse who is eligible for Medicare due to age (age 65 or over) has the same choice.

Contact the plan for further information.
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

The law requires that coverage under this plan be continued during a leave that is covered by the Act. Coverage must be the same as is provided under the plan to similar active participants. This means that when coverage is changed for similar active participants it will also change for the person on leave. The cost of such coverage will be:

1. For leaves of 30 days or less, the same as the participant contribution required for active participants;
2. For leaves of 31 days or more, up to 102% of the full contribution.

This Act only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the Act.

Coverage provided due to this Act will reduce any coverage required by COBRA.

Maximum Period of Coverage during Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date you fail to return to employment with the participating employer after completion of your leave. Participants must return to employment within:
   a. the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
   b. 14 days of completing military service, for leaves of 31 to 180 days,
   c. 90 days of completing military service, for leaves of more than 180 days; or
2. 24 months from the date your leave began.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law requires that coverage be reinstated upon your return to work. Reinstatement will apply whether coverage under the plan was maintained during the leave or not. To be eligible for reinstatement you must be honorably discharged from the military service and return to work within:

1. The first, full business day after your military service ends, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days after your military service ends, for leaves of 31 to 180 days;
3. 90 days after your military service ends, for leaves of more than 180 days.

You may be allowed more time to return to work if your military service: causes a sickness or injury; or worsens a sickness or injury. Your failure to return within the times stated must be due to such a sickness or injury. In that case, you may take up to a period of two years to return to work. If for reasons beyond your control you cannot return to work within two years, you must return as soon as is reasonably possible.
**USERRA - continued**

On reinstatement, all provisions and limits of the *plan* will apply to the extent that they would have had *you* not taken leave. The eligibility period will be waived.

This does not waive the *plan's* limits on *sickness* or *injury*: caused by *your* military service; or worsened by *your* military service. The Secretary of Veterans Affairs will determine if *your* military service caused or worsened a *sickness* or *injury*.

NOTE: For complete information regarding *your* rights under the Uniformed Services Employment and Reemployment Rights Act, contact the *plan*. 

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3-6
CONTINUATION OF BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a federal law. It applies to employers that have 20 or more employees. The law requires these employers to offer covered individuals continuation coverage (COBRA) under the plan if coverage is lost or cost increases due to specific events. COBRA must be offered at group rates. The employer cannot require evidence of good health as a condition of COBRA. COBRA must be the same as coverage for similar active participants under the plan. This means that when coverage is changed for similar active participants it will also change for the person on COBRA.

COBRA only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the COBRA.

Participant Rights to COBRA

A participant that is covered by this plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the participant's hours of work; or
2. The termination of the participant's employment. This will not apply if termination is due to gross misconduct on the participant's part.

Spouse Rights to COBRA

The spouse of a participant that is covered by this plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the participant's hours of work;
2. The termination of the participant's employment. This will not apply if termination is due to gross misconduct on the participant's part;
3. The death of the participant;
4. The end of the spouse's marriage to the participant. The marriage must end due to dissolution, annulment, divorce, or legal separation; or
5. The participant becoming entitled to Medicare.

Dependent Child Rights to COBRA

The dependent child of a participant that is covered by this plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the participant's hours of work;
2. The termination of the participant's employment. This will not apply if termination is due to gross misconduct on the participant's part;
3. The death of the participant;
4. The end of the participant's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;
5. The participant becoming entitled to Medicare; or
COBRA – continued

6. The child ceasing to be considered a dependent child as defined in this plan.

ELECTING COBRA

Each person covered by this plan has an independent right to elect COBRA for himself or herself. A covered participant or spouse may elect COBRA for all family members. A parent or legal guardian may elect coverage for a minor child.

If coverage has been terminated in anticipation of a qualifying event, the right to COBRA will still apply at the time of the event. In this case, COBRA will be effective on the date of the event even though it is after the date coverage was lost or cost increased.

If the participant's dependent child is born during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA. If a child is adopted by or placed for adoption with the participant during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA.

RETIREE COVERAGE (IF PROVIDED)

If coverage is lost due to the termination of retiree benefits, you have a right to elect COBRA. In certain circumstances, you may have the right to elect COBRA if retiree benefits are substantially eliminated. Termination or substantial elimination must occur within one year before or after the employer files Chapter 11 bankruptcy.

NOTICES AND ELECTION OF COVERAGE

Under the law, you must inform the plan administrator within 60 days of: a divorce; legal separation; annulment; or dissolution of marriage. You must also inform the plan administrator within 60 days of a child no longer meeting the plan's definition of dependent. The employer must notify the plan administrator of: the participant's death; termination of employment; reduction in hours of work; or Medicare entitlement. The employer must also notify the plan administrator of a termination or substantial elimination of retiree coverage due to Chapter 11 bankruptcy. See Procedures for Providing Notice to the Plan for further information.

Within 14 days of receiving notice that one of the above events has happened, the plan administrator will notify you that you have the right to elect COBRA. If the employer and plan administrator are the same entity, notice of the right to elect will be provided within 44 days. Under the law you must elect COBRA within 60 days from the later of: the date you would lose coverage or cost would increase due to the qualifying event; or the date notice of your right to COBRA and the election form are sent.

The plan administrator must provide you with a quote of the total monthly cost of COBRA. The initial payment is due by the 45th day after coverage is elected. All other payments are due on a monthly basis, subject to a 30 day grace period.

If you elect COBRA within the 60 day period, COBRA will be effective on the date that you would lose coverage. If you do not elect COBRA within this 60 day period, COBRA will not be available. Your coverage under the plan will terminate.

If you elect COBRA, it is your duty to pay all of the monthly payments directly to the plan administrator. The cost of COBRA must be a reasonable estimate of the cost of coverage had it not ended. The plan may add a 2% administration charge to that cost. The plan may charge an additional 50% during the 11 month extension for total disability if the disabled individual is covered. If the disabled individual is not covered, only the 2% administration charge will apply during the extension.

Revised 1/1/12
COBRA – continued

Payments for COBRA may only be increased once during any one 12 month period. The timing of the 12 month period is set by the plan administrator.

Maximum Period of Continuation of Coverage
When coverage is lost or cost increases the law requires that the employer maintain COBRA for up to:

1. 18 months, if due to the participant’s termination of employment. Termination must be for reasons other than gross misconduct on the participant’s part;

2. 18 months, if due to the participant’s reduction in work hours;

3. 36 months, if due to the death of the participant;

4. 36 months, if due to the end of the participant's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. 36 months, if due to the participant becoming entitled to Medicare. If coverage is not lost or cost does not increase until a later date, COBRA will end at the later of: 36 months from the date of the participant's Medicare entitlement; or the maximum period of COBRA allowed due to the event that caused the loss of coverage or increase in cost;

6. 36 months, if due to your ceasing to be a dependent child as defined in the plan; or

7. The lifetime of the retiree, if due to the termination of retiree benefits. The same period will apply if due to the substantial elimination of retiree benefits. Termination or substantial elimination must occur within one year before or after the employer files Chapter 11 bankruptcy. Upon the retiree's death, any covered dependent may elect COBRA for an additional 36 months from that date.

If you or a dependent are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if you or a dependent become disabled during the first 60 days of COBRA. You must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. You must provide notice to the plan administrator within 60 days after such determination of disability is made. This notice must also be prior to the end of the 18 month COBRA period. If notice is not given within these times, you will not be eligible for the extended period. If it is determined that you are no longer disabled, you must notify the plan administrator within 30 days of that final determination. The right to this extended period applies to each individual. It will apply even if the disabled individual does not remain covered. See Procedures for Providing Notice to the Plan for further information.

If a second event occurs during the initial 18 or 29 month period, COBRA may be extended to 36 months. Second events include: the participant's death; the participant's divorce; a child no longer meeting the definition of dependent. A second event will not result in an extension of COBRA, if the event would not result in a loss of coverage for an active participant or dependent. Except in the case of bankruptcy the period will not exceed 36 months from the date of the original event.

The maximum coverage period is measured from the date of the qualifying event. This is true even if the qualifying event does not result in a loss of coverage or increase in cost until a later date.

If COBRA is rejected in favor of an alternate coverage under the plan, COBRA will not be offered at the end of that period. If an alternate coverage is offered, COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other plan provision.

Revised 1/1/12
COBRA – continued

Termination Before the End of the Maximum Coverage Period
The law allows COBRA to be terminated prior to the end of the maximum period. Such termination can only be for one of the following reasons:

1. The plan administrator no longer provides a group benefit plan to any of its participants;

2. The payment for COBRA is not paid on time. Monthly payments are subject to a 30 day grace period. If a payment is on time and not significantly less than the amount due, it will be considered full payment unless notice of the amount due is provided to you. You will have 30 days from the date of notice to make the additional payment;

3. You obtain another group plan after the date you elect COBRA. This will not apply if that group plan has a pre-existing condition exclusion or limit that applies to you. If such limit or exclusion has been met by a credit from your previous coverage, this provision will apply. If your new plan does have a pre-existing condition exclusion or limit that applies to you, then COBRA will end on the earlier of: the date that exclusion or limit no longer applies to you; or the end of the maximum coverage period;

4. You become entitled to Medicare after the date you elect COBRA;

5. There has been a final determination that you are no longer disabled. Such determination must be made under Title II or XVI of the Social Security Act. This will only apply during the 11 month extension of COBRA due to disability. In this case, COBRA will not end until the first day of the month that is more than 30 days after the determination.

Additional Election Period due to The Trade Act of 2002
If you did not elect COBRA during the election period described above, another 60 day period may be presented for you to elect COBRA. If your loss of coverage was due to a Trade Adjustment Assistance (TAA) event and you are determined to be TAA eligible during the six month period following your loss of coverage, you will have an additional period in which to elect COBRA. This election period will begin the first of the month in which you become TAA eligible. The period will end on the earlier of: 60 days from the date it began; or the end of the six month period following your loss of coverage due to a TAA event.

If you elect COBRA during this TAA election period, COBRA will be effective on the first of the month in which you became TAA eligible. COBRA will not be provided for the period of time between your loss of coverage and the first of the month in which you became TAA eligible. However, that time will not be counted as a lapse in coverage for purposes of determining if the plan’s pre-existing condition exclusion will apply. In this case, the maximum period of coverage will be counted from the date you lost coverage under the plan, not the date COBRA is effective. If you do not elect COBRA within this period, COBRA will not be available again.

If you elect COBRA, it is your duty to pay all of the monthly payments directly to the plan administrator. The Trade Act of 2002 did create a tax credit for TAA eligible individuals. Under the Act up to 72.5% of the cost of COBRA can be taken as a tax credit. The Act also provides an option for an advance payment of the tax credit toward the cost of COBRA. If you have questions about this tax credit, call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. Additional information about the Trade Act of 2002 can be found at www.doleta.gov/tradeact.
COBRA – continued

**Procedures for Providing Notice to the Plan**
In order to maintain your rights under COBRA, you are required to provide the plan with notice of certain events, as described above. The plan will consider your obligation to provide notice satisfied if you provide written notice to the plan administrator that includes:

1. The participant’s name and participant number;
2. The name of the individual(s) to whom the notice applies;
3. The reason for which notice is being provided; and
4. The address and phone number where you can be contacted.

Notice should be addressed to the American Maritime Officers Medical Plan, Attn: COBRA Administration. Notice should be mailed to the plan administrator’s address shown in this plan. Your notice will not satisfy your obligation if it is not provided within the time frame stated above for that notice.

**Other Information**
The plan administrator will answer any questions you may have on COBRA. You can also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) for answers to your questions. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA’s website at www.dol.gov/ebsa.

To protect your rights under COBRA, you should notify the plan administrator of any changes that affect your coverage. Such changes include a change for you or a family member in marital status; address; or other insurance coverage. When providing any notice to the plan, a copy should be maintained for your own records.
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SECTION 4  GENERAL PLAN INFORMATION
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PLAN DESCRIPTION INFORMATION

The Board of Trustees sets the benefits under the plan. The Board of Trustees sets the rights and privileges of plan participants to those benefits. The plan is self-funded and pays benefits from a fund established by the Board of Trustees, as needed.

Each participant in the plan will receive this Summary Plan Description (SPD). It contains information on: eligibility; termination; benefits provided; and other general plan provisions.

The purpose of this SPD is to set forth the provisions of this plan. The plan provides for the payment or reimbursement of eligible medical expenses.

If there is a conflict between the official Plan document and this SPD, the language of the Plan document will govern.

PLAN NAME
American Maritime Officers (AMO) Medical Plan

TYPE OF PLAN
A self-funded, multiemployer welfare plan that provides medical benefits to covered participants and dependents.

This plan is not financed or administered by an insurance company. The plan's benefits are not guaranteed by a contract of insurance.

GROUP NUMBER
0081717

PLAN YEAR FOR GOVERNMENT REPORTING
October 1 to September 30

PLAN ADMINISTRATOR/
PLAN SPONSOR
Board of Trustees
American Maritime Officers Medical Plan
2 West Dixie Highway
Dania Beach, FL 33004
(800) 348-6515

PLAN NUMBER
#501

EMPLOYER IDENTIFICATION NUMBER
13-5600786

CLAIMS ADMINISTRATOR
UMR, Inc.
P.O. Box 826
Onalaska, WI 54650
(866) 983-4879

AGENT FOR SERVICE OF LEGAL PROCESS
Board of Trustees
American Maritime Officers Medical Plan
2 West Dixie Highway
Dania Beach, FL 33004
(800) 348-6515

Legal process may also be served on any plan Trustee.

Revised 1/1/12
STATEMENT OF ERISA RIGHTS

PARTICIPANT RIGHTS
As a participant covered by this welfare plan, you have certain rights through the Employee Retirement Income Security Act of 1974 (ERISA). You also have certain protections through ERISA. ERISA provides that all covered participants will be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, all documents governing the plan. You may examine them at the plan administrator's office. You may also examine them at other specified locations, such as worksites and union halls, if any. This includes insurance contracts and collective bargaining agreements, if any. It also includes the latest annual report (Form 5500 Series) filed by the plan with U.S. Department of Labor, if filing is required by law. These filings are available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of documents governing the plan. This includes insurance contracts and collective bargaining agreements, if any. It also includes the latest annual report (Form 5500 Series), if the report is required by law, and an updated summary plan description. Written request must be made to the plan administrator. The plan administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if one is required by law. If a summary annual report is required, the plan administrator is required by law to furnish each covered participant with a copy of this summary annual report.

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 may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of any pre-existing condition exclusion under this group health plan, if you have creditable coverage from another plan. You should be given a certificate of creditable coverage, free of charge, by the group health plan or health insurance issuer you lose coverage under. The certificate of creditable coverage should be given to you when you lose coverage, become entitled to elect COBRA continuation coverage, and when COBRA continuation coverage ends. If you request it, a certificate of creditable coverage should also be given to you at any time during the 24 months after you lose coverage. Without proof of creditable coverage, you may be subject to a pre-existing condition exclusion of up to 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
ERISA also imposes duties on the people who are responsible for the plan. The people who operate the plan are called "fiduciaries" of the plan. They have a duty to operate the plan prudently and in the interest of you and other covered persons. No one may fire or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. This includes your participating employer, your union if any or any other person.
ERISA Rights – continued

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done with certain time frames. You have a right to obtain copies of documents relating to the decision without charge and within certain time frames. You also have the right to appeal any denial, within certain time frames.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if materials, such as plan documents or the latest annual report, that you asked the plan for are not received within 30 days, you may file suit in Federal court. In such a case, the plan administrator may be ordered to provide you with the materials. The plan administrator may also be ordered to pay you up to $110 a day until the materials are received. If the materials were not sent due to reasons beyond the plan's control, penalties will not be imposed.

If you have a claim or part of a claim for benefits that is denied or ignored, you may file suit in state or Federal court. In addition, if you do not agree with the plan's decision or lack of decision on the qualified status of a medical child support order, you may file suit in Federal court. If the plan's 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 file suit in a Federal court. The court will decide who should pay filing costs and legal fees. If you are successful, the person you have sued may be ordered to pay these costs and fees. If you lose, for example, your claim is found frivolous; you may be ordered to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement, you should contact the nearest office of the Employee Benefits Security Administration (EBSA). If you have any questions about your rights under ERISA, you should contact the nearest office of the EBSA. If you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the EBSA. You can contact the EBSA at the U.S. Department of Labor number listed in your telephone directory. You can also contact them at the Division of Technical Assistance and Inquiries; Employee Benefits Security Administration, U.S. Department of Labor; 200 Constitution Avenue N.W.; Washington, D.C. 20210. Certain publications about your rights and responsibilities under ERISA can be obtained by calling the publications hotline of the EBSA.
COORDINATION OF BENEFITS

Benefits Subject to This Provision
This plan's benefits are coordinated with benefits provided by other plans that cover you or your dependents. This is done to prevent over insurance, which would result in an increase in the cost of coverage under this plan. This provision will apply whether or not you file a claim under any other plan that covers you.

Effect on Benefits
In certain cases, this plan's benefits will be reduced when you are covered by other plans that provide benefits for the same service. Benefits under this plan and any other plans, as defined below, will be coordinated. The total benefit will not exceed the amount this plan would have paid for the covered expenses had it been primary.

Definitions
A plan is any coverage that provides benefits for medical or dental expenses. Benefits may be provided by payment or service. Plan includes any of the following:

1. Group or franchise insurance coverage, whether insured or self-funded;
2. Hospital or medical service organizations on a group basis and other group pre-payment plans;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage sponsored or provided by or through an educational institution;
5. Any governmental program or a program mandated by state statute;
6. Any coverage sponsored or provided by or through an employer, trustee, union, employee benefit, or other association.

This includes group type contracts not available to the general public. Such contracts may be obtained due to the covered person's membership in or connection with a particular group. This provision will apply whether or not such coverage is designated as franchise, blanket, or in some other fashion.

This does not include group or individual automobile "no fault" or traditional "fault" type contracts. It does not include school or other similar liability type contracts. Nor does it include other types of contracts claiming to be excess or contingent in all cases.

The plan will not pay benefits relating to an automobile accident until all benefits payable under any automobile insurance policies have been paid and exhausted. The 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 payable under the plan.

How Coordination of Benefits Works
One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. This plan, when secondary, will make up the difference between this plan's normal payment and the amount paid by the primary plan.

When a plan provides benefits in the form of services rather than cash payments, the customary, usual and reasonable value of each service will be deemed to be the benefit paid. No plan will pay more than it would have paid without this provision.
Dependent Spouse Employed Full-Time

The AMO Medical Plan Rules and Regulations regarding coordination of benefits for a dependent spouse require that the plan consider group medical coverage offered through a dependent spouse’s full-time employment first and the AMO medical plan will be secondary. If the dependent spouse does not elect coverage through their own employer, coverage under the AMO plan will not be available. In addition, if the rules and regulations of the primary insurer are not followed by the dependent, the AMO plan will not pay any of the otherwise eligible benefits on behalf of such dependent. Full-time employment means 30 hours or more per work week. This provision will also be applicable to any eligible dependent children who can obtain coverage at no-cost through the spouse’s employer.

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 copays, deductible and coinsurance).

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 dependent 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 dependent spouse’s employer participates in an HMO, PPO, or other managed care plan, the dependent spouse must follow the rules of that plan. If the dependent spouse does not follow the rules of their primary insurer, the AMO medical plan will not pay any of the otherwise eligible benefit.

Dependent Child

If a dependent child is covered at no cost through a group plan by virtue of the dependent spouse’s full-time employment or if the dependent spouse elects family coverage, benefits for the dependent child will be coordinated in accordance with the Order of Benefit Determination section. Please note that a dependent spouse who is employed full-time is not required to take family coverage unless it is without cost.

Order of Benefit Determination

The primary plan will be determined by the following rules. That plan will pay benefits first.

1. The plan that has no coordination provision will be primary.

2. The plan that covers the person as an active policy holder (such as employee, member or participant) will be primary.

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the calendar year will be primary. If both parents have the same birthday, the plan covering a parent for the longest period of time will be primary.

4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents rule 3. will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary. 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.

5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:
Coordination of Benefits - continued

a. the plan of a parent who has primary physical placement will be primary,
b. the plan of a step-parent that has primary physical placement will pay benefits next,
c. the plan of a parent who does not have primary physical placement will pay benefits next, and
d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

Unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary. 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.

6. The plan covering an inactive person: laid off; retired; on COBRA or any other form of continuation; or the dependent of such a person will pay benefits after the plan covering such persons as an active employee or the dependent of an active employee.

7. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active employee or the dependent of an active employee.

When an individual is covered under a spouse’s plan and also under his or her parent’s plan, the primary plan is the plan of the individual’s spouse. The plan of the individual’s parent(s) is the secondary plan.

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If all plans have covered the person for the same period of time, the plans will share equally in the allowable expenses. In no event, will any plan pay more than it would have paid as primary.

If a plan other than this plan does not include provision 3., then that provision will be waived in order to determine benefits with the other plan.

Coordination of Benefits between Medical and Dental Plans

In all cases, the dental plan will be secondary. It will only pay benefits after the medical plan pays its benefits as the primary plan.

Coordination of Benefits with Medicare – Effective 1/1/12 to 9/30/12

In all cases, coordination with Medicare will conform to Federal Statutes and Regulations. Each pensioner and their eligible dependents that are eligible for Medicare will be assumed to have full Medicare coverage. Full Medicare coverage is: Part A hospital insurance; and Part B voluntary medical insurance. For pensioners, if you are eligible for Part B but do not enroll or are residing in a foreign country, the plan will reimburse covered expenses at 20% of the otherwise eligible benefit.

Coordination of Benefits with Medicare- Effective 10/1/12

In all cases, coordination with Medicare will conform to Federal Statutes and Regulations. Please note the following:

1. For pensioners and their dependent spouses who are residing in a foreign country, the plan will reimburse covered expenses at 20% of the otherwise eligible Medicare benefit (both Part A and B);
2. For pensioners and their eligible dependents, each must enroll in both Medicare Part A and Part B as soon as it is offered to you. Failure to enroll in both Medicare Part A and Part B coverage will result in benefits not being payable by the plan.
Additional Information Regarding Medicare

*Your* benefits under this *plan* are subject to the allowable limiting charges set by *Medicare*. Benefits will be coordinated to the extent they would have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an employee, dependent or other.
RECOVERY RIGHTS

GENERAL RECOVERY RIGHTS PROVISIONS

APPLICABLE TO RIGHT OF SUBROGATION, RIGHT OF REIMBURSEMENT,
EXCESS COVERAGE PROVISION AND WORKERS' COMPENSATION

By accepting benefits paid by this plan, you agree to all of the following conditions. The payment of any claims by the plan is an advancement of plan assets. The plan has first priority to receive repayment of those plan assets out of any amount you recover. The plan's recovery rights have first priority over any and all other claims to recover damages, including first priority to receive payment from any liable or responsible party before you receive payment from that party. The plan's recovery rights will apply regardless of whether the amount of health care expense is agreed upon or defined in any settlement or compromise. The plan's recovery rights will apply even if any health care expense is excluded from the settlement or compromise. These rights will apply regardless of whether or not you are made whole.

The plan will not pay attorney fees without the express written consent of the plan administrator. The plan will not pay any costs associated with any claim or lawsuit without the express written consent of the plan administrator.

If you are deceased, the rights and provisions of this section will apply equally to your estate. If you are legally incapacitated the rights and provisions of this section will apply equally to your legal guardian.

In consideration of the coverage provided by this plan, when you file a claim you agree to all of the following conditions. You will sign any documents that the plan considers necessary to enforce its recovery rights. You will do whatever is necessary to enable the plan to exercise its recovery rights. You will follow the provisions of this section and do nothing at any time to prejudice those rights. You will assign to the plan any rights you have for expenses the plan paid on your behalf. You will hold any settlement funds in trust, either in a separate bank account in your name or in your attorney’s trust account, until all plan assets are fully repaid or the plan agrees to disbursement of the funds in writing, if you receive payment from any liable or responsible party and the plan alleges that some or all of those funds are due and owed to the plan. You will serve as a trustee over those funds to the extent of the benefits the plan has paid.

For the purposes of this provision, the following definitions will apply:

1. Health care expense means any medical, dental or loss of time expense that has been paid by the plan. It also includes any medical, dental or loss of time expense that may be payable by the plan in the future.

2. Any responsible or liable party means the responsible or liable party; any liability or other insurance covering the responsible or liable party; you or your covered dependent's own uninsured motorist insurance or under insured motorist insurance; any medical payment, no-fault or school insurance coverage.

You have a duty to cooperate with the plan in the pursuit of any recovery. Failure to comply with the requirements of this section may result in the loss of your benefits under this plan.

Right of Subrogation

If, after payments have been made under this plan, you have a right to recover damages from a responsible or liable party, the plan shall be subrogated to that right to recover. The plan's right of subrogation is to full recovery. It may be made from any responsible or liable party. It will be to the extent of expenses that are paid or payable for any health care expenses under the plan.
Recovery Rights - continued

Right of Reimbursement
If benefits are paid under this plan and you recover from a responsible or liable party by settlement, judgment or otherwise, the plan has a right to recover from you. Recovery will be in an amount equal to the amount of plan assets paid on your behalf. The plan's right of reimbursement may be from funds received from any responsible or liable party. It will be to the extent of plan assets that are paid or payable for any health care expenses under the plan.

Excess Coverage Provision
Benefits are not payable for an injury or sickness if there is any responsible or liable party providing coverage for health care expenses you incur. This will apply regardless of whether such other coverage is described as primary, excess or contingent. In order to avoid delays in the paying of claims the plan may make payments on your behalf for covered expenses for which there is other insurance providing medical payments or health care expense coverage. Such payments are at the sole discretion of the plan and will be considered an advancement of plan assets to you.

This plan does not provide benefits or may reduce benefits for any present or future covered expenses that you have been compensated for. This will apply to the extent of any recovery by settlement, judgment or otherwise from any responsible or liable party. Benefits may be denied or reduced regardless of whether such recovery or part thereof is specifically denominated for health care expenses, personal injuries, lost wages or any other loss. Any reduction or denial of benefits is at the sole discretion of the plan.

Workers' Compensation
This plan excludes coverage for any injury or sickness that is eligible for benefits under Workers' Compensation. If benefits are paid by the plan and you receive Workers' Compensation for the same incident, the plan has the right to recover. That right is described in this section. The plan reserves its right to exercise its recovery rights against you even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the injury or sickness was sustained in the course of or resulted from your employment;
3. The amount of Workers' Compensation due to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or
4. The health care expense is specifically excluded from the Workers Compensation settlement or compromise.
GENERAL PROVISIONS

The following provisions are to protect your legal rights and the legal rights of the plan.

PLAN ADMINISTRATION

A joint Board of Trustees administers the plan. The names of current Trustees are listed on Appendix A. 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 Appendix B. 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.

AMENDMENTS TO OR TERMINATION OF THE PLAN

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:

1. 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

2. 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

3. 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.

ASSIGNMENT

Any assignment will only be applied if the provider will refund any payments made in error. The plan does not attest to the legal validity or effect of any assignment.

CONFORMITY WITH APPLICABLE LAWS

If any part of this plan conflicts with any law that applies to the plan, it is hereby amended to comply with that law.

CONTRIBUTIONS TO THE PLAN

Participating employers make contributions to the plan on behalf of their participants. The amounts of the contributions, which are based on days of employment, are negotiated as collective bargaining agreements are renewed.

Any funds contributed by the participating employers are applied to the expenses of the plan as soon as is reasonably possible. Any excess funds are used to pay claims. The Board of Trustees sets the amount of the contribution. All contributions are on a non-discriminatory basis.
DISCRETIONARY AUTHORITY

Benefits under this plan will be paid only if the plan administrator decides in its discretion that the covered person is entitled to the benefits. The plan administrator will have full discretion to interpret plan terms; make decisions regarding eligibility; and resolve factual questions. This discretion will apply with respect to all claim payments and benefits under the plan.

FAILURE TO ENFORCE PLAN PROVISIONS

The plan's failure to enforce any part of the plan will not affect the right, thereafter, to enforce that provision. Such failure will not affect the right to enforce any other provision of the plan.

FRAUD

Fraud is a crime that can be prosecuted. Any covered person who willfully and knowingly engages in an activity intended to defraud the plan is guilty of fraud. The plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a covered person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the plan. In addition, it is a fraudulent act when a covered person willfully and knowingly fails to notify the plan regarding an event that effects eligibility for a covered person. Prior authorization requirements are outlined in this summary plan description and other plan materials. Please read them carefully and refer to all plan materials that you receive (i.e., COBRA notices). A few examples of events that require plan notification would be divorce, dependent child reaching the limiting age, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the covered person’s claim or termination from the plan, and are subject to prosecution and punishment to the full extent under state and/or federal law. The plan will pursue all appropriate legal remedies in the event of fraud.

Covered persons must:

1. File accurate claims. If someone else, such as your spouse or another family member, files claims on the covered person’s behalf, the covered person should review the form before signing it;

2. Review your Explanation of Benefits (EOB). Make certain that benefits have been paid correctly based on your knowledge of the covered expense and the services received;

3. Never allow another person to seek medical treatment under your identity. If your plan ID card is lost, report the loss to the plan administrator immediately; and

4. Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

5. Notify the plan when an event occurs that effects a covered person’s eligibility.

To maintain the integrity of this plan, covered persons are encouraged to notify the plan whenever a provider:

1. Bills for services or treatment that have never been received; or

2. Asks a covered person to sign a blank claim form; or

3. Asks a covered person to undergo tests that the covered person feels are not needed.

Covered persons concerned about any of the charges that appear on a bill or EOB, or who know of or suspect any illegal activity, should call the toll-free fraud hotline 1-800-356-5803. All calls are strictly confidential.
FREE CHOICE OF PROVIDER
The covered person has a free choice of any legally licensed provider. The plan will not interfere with the provider/patient relationship.

INTERPRETATION
This plan does not constitute a contract between the employer and any covered person. It will not be considered as an incentive or condition of employment. The plan will not modify the provisions of any collective bargaining agreement that may be made by the employer. A copy of any such agreement is available from the plan administrator upon written request.

LEGAL ACTIONS
You may bring an action at law or equity against the plan. Such action may not be sought until 60 days after the date you provide written proof of loss to the plan. If an alternative method of dispute resolution has been agreed to, action at law or equity may not be sought until the end of that process. Any such action cannot be sought more than three years after such proof of loss is submitted.

PAYMENT OF CLAIMS
All benefits (except for prescription drugs) will be paid directly to the provider of services, unless you direct otherwise in writing at the time proof of loss is filed.

Benefits payable on behalf of you or your covered dependent, upon death, will be paid at the plan's option to any one or more of the following: your spouse; your dependent children, including legally adopted children; your parents; your brothers and sisters; or your estate.

Any payment made in good faith will fully discharge the plan of its obligations to the extent of such payment.

PHYSICAL EXAMINATION
The plan has the right to have you examined as often as reasonably necessary while a claim is pending. Such examination will be at the plan's expense.

PRIVACY
The Board of Trustees of the AMO Medical Plan, who is the sponsor of this plan, will receive protected health information. The information may be identified to the individual in some cases. The Board of Trustees is limited in how it may use this information. Its uses and disclosures must be necessary to carry out plan functions. The plan functions must relate to payment or health care operations, as defined in 45 CFR Subtitle A, Subchapter C, Part 164 - Security and Privacy. It may also use or disclose the information as required by law. Prior to receiving any protected health information the Board of Trustees must certify to the plan that it agrees to:

1. Not use or disclose the information, except as stated above;
2. Require that any agent or subcontractor of the Board of Trustees agree to the same limits that apply to the Board of Trustees prior to giving the information to them;
3. Not use or disclose the information for employment related decisions or actions;
4. Not use or disclose the information in connection with other benefit plans the Board of Trustees may sponsor;
5. Report to the plan any use or disclosure that does not comply with this General Provision;

Revised 1/1/12
General Provision for Privacy – continued

6. Make the information available for review by the person that it relates to;

7. Make the information available for amendment and include any amendments with it;

8. Provide the necessary information to give an accounting of disclosures;

9. Make its internal practices, books and records in relation to the information open for review by the Secretary of Health and Human Services;

10. Return or destroy all information when it is no longer needed. If that is not possible, limit any further use or disclosure to the reason it was not possible to return or destroy it;

11. Maintain adequate separation between the plan and itself. Access to the information will be limited to members of the Board of Trustees, Accountant, Consultant, and Attorney that work with the plan. These individuals will receive the minimum necessary information to carry out the plan functions they perform;

12. Provide an effective process to address non-compliance by the Board of Trustees or its agents or subcontractors.

PRONOUNS

All personal pronouns used in the plan include either gender. This will be true unless its use clearly indicates otherwise.

PROTECTION AGAINST CREDITORS

Benefit payments under the plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish these will be void. If the plan finds that such an attempt has been made, it, at its sole discretion, may terminate your interest in the payments. The plan will then apply the amount of the payment to the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the covered person. Such payment will fully discharge the plan to the extent of the payment.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If a child is the subject of a Qualified Medical Child Support Order (QMCSO), the child must be considered an alternate recipient under the plan. Upon the plan's decision that an order is a QMCSO, coverage must be provided to the child. Coverage may not be subject to plan requirements such as: custody; claimed on taxes; or 50% support. Enrollment periods and other similar limits on the eligibility of dependents are also waived for that child. If a participant does not enroll the child in the plan, the plan must recognize the child's right to be enrolled as an alternate recipient. The custodial parent or legal guardian of the child may also exercise this right.

An alternate recipient will be as a participant under the plan for the purpose of reporting and disclosure under ERISA. The custodial parent or legal guardian may have this right on behalf of the alternate recipient. They must receive all information needed to be enrolled in and receive benefits under the plan. They must be provided with a copy of the plan's Summary Plan Description (SPD). Any payments made by the plan must be made to the alternate recipient or the provider of service. Payment may also be made to the custodial parent or legal guardian.

A QMCSO is any judgment, decree or order relating to the benefits of this plan for the child of a participant. It may be issued pursuant to State domestic relations law, including community property law. It may be issued to enforce a law relating to medical child support under the Social Security Act. The order may be from a court of
General Provision for QMCSO – continued

The order must include the following items to be considered a QMCSO:

1. The name and last known mailing address of the participant;
2. The name and address of each alternate recipient;
3. A description of the type of coverage to be provided or the manner in which coverage will be determined for each alternate recipient; and
4. The period of time for which coverage is to be provided to each alternate recipient.

The plan will provide you with a written notice of its decision regarding the status of an order as a QMCSO. A properly completed National Medical Support Notice will be treated as a QMCSO under this plan.

A QMCSO will not require the plan to offer any benefits or coverage not already offered by the plan.

RIGHT TO NECESSARY INFORMATION

The plan may require certain information in order to apply the provisions of this plan. To get this information the plan may release or obtain information from any party it needs to. The exchange of such information will not require your consent. Any party may include an insurance company, organization or person. Information will only be exchanged to the extent needed to implement the provisions of the plan. You agree to furnish any information needed to apply the plan provisions.

RIGHT TO RECOVER

The plan reserves the right to recover payments made under the plan. Recovery is limited to the amount that exceeds the amount the plan is obligated to pay. This right of recovery applies against:

1. Any person(s) to, for or with respect to whom such payments were made; and
2. Any insurance company or organization. If under the terms of this plan, it owes benefits for the same expense under any other plan.

The plan alone shall determine against whom this right of recovery will be exercised.

If benefits have been paid by any other plan that should have been paid by this plan, the plan reserves the right to directly reimburse such plan. Reimbursement will be to the extent needed to satisfy the obligations of this plan. Any such payment made in good faith will fully discharge the plan of its obligation to the extent of such payment.

The plan will in any event have the right to take legal or other action to collect overpayment(s) upon due notice.

SECURITY

The Board of Trustees, who is the sponsor of this plan, will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Board of Trustees certifies to the plan that it agrees to:

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;
General Provision for Security – continued

2. Require that any agent or subcontractor of the Board of Trustees agrees to the same requirements that apply to the Board of Trustees under this provision;

3. Report to the plan any security incident that the Board of Trustees becomes aware of; and

4. Apply reasonable and appropriate security measures to maintain adequate separation between the plan and itself.

STATEMENTS

In the absence of fraud, all statements made by a covered person will be deemed representations and not warranties. A statement will not be used to contest coverage under the plan unless a signed copy of it has been provided to the covered person. If the covered person is deceased, the copy will be provided to their beneficiary.

TIME OF CLAIM DETERMINATION

After receipt of written proof of loss or utilization review request, the plan will notify you of its decision on your claim and issue payment, if any is due, as follows:

Urgent Care

Within 24 hours or as soon as possible if, your condition requires a shorter time frame. If more information is needed to make a decision on the claim, the plan will notify you of the specific information needed within 24 hours. You will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of its receipt of the additional information, the plan will give its decision on the claim. If you fail to provide the information requested by the plan, the plan will provide you with its decision on the claim within 48 hours of the end of the period that you were given to provide the information.

If you fail to follow the plan procedure for a pre-service claim, the plan will notify you within 24 hours of the plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Concurrent Care

Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for you to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a plan amendment. This will not apply if the benefit is being stopped due to the termination of the plan.

Requests to extend a pre-authorized treatment that involves urgent care must be responded to within 24 hours or as soon as possible if, your condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

Pre-Service Claims

Within 15 days of receipt of a non-urgent care claim. The plan may extend this period by 15 days if; you are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the plan's control. If an extension is due to the need for additional information, the plan will notify you of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

Revised 1/1/12
Time of Claim Determination – continued

If you fail to follow the plan procedure for a non-urgent care pre-service claim, the plan will notify you within five days of the plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Post-Service Claims
Within 30 days of receipt of the claim. The plan may extend this period by 15 days if; you are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the plan’s control. If an extension is due to the need for additional information, the plan will notify you of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

WORKERS' COMPENSATION NOT AFFECTED
This plan is not issued in lieu of Workers' Compensation coverage. It does not affect any requirement for coverage by any Workers' Compensation Law. It does not affect any requirement for coverage by any Occupational Disease Act.
CLAIM APPEAL PROCEDURE

APPEAL OF DENIED CLAIMS

If your claim for benefits is denied in whole or in part, you have the right to file an appeal for review. A request for review of a medical, hospital, surgical, 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.

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. The plan provides three levels of appeal. First and second level appeals should be submitted to: UMR Appeals, 333 West Vine Street Suite #500, Lexington KY 40507. A request for an expedited appeal may be made by calling (800) 236-8672. Third level appeals should be submitted to the Board of Trustees of 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. 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).

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 participant/dependent or when requested due to failure to authorize a continuing inpatient hospital stay.

1. An attending physician, ordering provider, facility rendering service, and/or the patient/claimant can request an Expedited Appeal.

2. UMR Medical Director explains expedited appeal process upon initial review denial.

3. UMR 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.

4. Notification letters are generated to all parties.

FIRST LEVEL APPEAL

1. Request for appeal is received and forwarded to Appeals Coordinator within 1 calendar day.

2. 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.
Claim Appeal Procedure – continued

1. Extension notification letter is generated informing member/dependent of 15 day extension time to complete request.

2. Case reviewed by UMR Medical Director of an appropriate expertise, but not involved in the initial non-certification recommendation.

3. Review completed within 15 calendar days for prospective reviews and 60 calendar days for retrospective reviews (75 days if extension requested).

4. Medical Director overturns original non-certification. Notification letters are generated to all parties.

5. 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

1. You may file a second level appeal no later than 60 days from your receipt of notice of denial of the first level appeal.

2. Request for appeal received and forwarded to Appeals Coordinator within 1 calendar day.

3. Receipt notification letter sent within 2 calendar days to the requesting party, communicating that information received and the expected review completion timeframe.

4. Additional information may be requested from the treating provider. Extension notification letter is generated informing participant/dependent of 15 day extension time to complete request.

5. Review completed within 15 calendar days for prospective reviews and 60 calendar days for retrospective reviews (75 days if extension requested).

6. Medical Director overturns original non-certification. Notification letters are generated to all parties.

7. 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 APPEAL

You may file a third level appeal no later than 60 days from your receipt of notice of denial of the second level appeal. All requests must be in writing and submitted to: UMR Appeals, 333 West Vine Street Suite #500, Lexington KY 40507.

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. 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.

Revised 1/1/12
Claim Appeal Procedure – continued

*You also have the right to appear in person before the Trustees (or Subcommittee).*

**FEDERAL EXTERNAL REVIEW PROGRAM**

If, after exhausting *your* internal appeals, *you* are not satisfied with the final determination, *you* may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

1. Clinical reasons;

2. The exclusion for experimental or investigational services or unproven services; or

3. As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to *you* after exhausting the appeals process identified above and *you* receive a decision that is unfavorable, or if UMR, Inc. or the plan administrator fail to respond to *your* appeal within the time lines stated above.

*You* may request an independent review of the adverse benefit determination. Neither *you* nor UMR, Inc. or the plan administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer’s decision. If *you* wish to pursue an external review, please send a written request to the following address:

UMR, INC.
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

*Your* written request should include:

1. *Your* specific request for an external review;

2. The participant's name, address, and member ID number;

3. *Your* designated representative's name and address, when applicable;

4. The service that was denied; and

5. Any new, relevant information that was not provided during the internal appeal.

*You will be provided more information about the external review process at the time we receive your request.*

All requests for an independent review must be made within four (4) months of the date *you* receive the adverse benefit determination. *You, your* treating physician or an authorized designated representative may request an independent review by contacting the toll-free number on *your* ID card or by sending a written request to the address on *your* ID card.
Claim Appeal Procedure – continued

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a covered expense by the plan. The Independent Review Organization (IRO) has been contracted by UMR, Inc. and has no material affiliation or interest with UMR, Inc. or the plan administrator. UMR, Inc. will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR’s receipt of a request for independent review, the request will be forwarded to the IRO, together with:

1. All relevant medical records;
2. All other documents relied upon by UMR, Inc. and/or the plan administrator in making a decision on the case; and
3. All other information or evidence that you or your physician has already submitted to UMR, Inc. or the plan administrator.

If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and UMR, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer’s decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and UMR, Inc. and/or the plan administrator with the reviewer’s decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the plan. If the final independent review decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the service or procedure.

You may contact the claims administrator at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

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 UMR 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.
Claim Appeal Procedure – continued

The decision of UMR 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:

1. The specific reasons for the determination;

2. Reference to the specific provisions of the Rules and Regulations or procedures on which the determination is based;

3. 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;

4. 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;

5. 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;

6. 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 exhausted the appeal process described above 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 Benefits Services Office at 1-800-348-6515 extension 12 or UMR at (866) 983-4879. Claim forms, where necessary, should be submitted to the AMO Medical Plan, 2 West Dixie Highway, Dania Beach, Florida 33004-4312 or to the PPO at the address indicated on the identification card.
## APPENDIX A – AMO MEDICAL PLAN
### BOARD OF TRUSTEE MEMBERS

<table>
<thead>
<tr>
<th>UNION TRUSTEES</th>
<th>EMPLOYER TRUSTEES</th>
</tr>
</thead>
</table>
| **Thomas Bethel**  
National President  
American Maritime Officers  
490 L’Enfant Plaza East, S.W.  
Suite 7204  
Washington, DC 20024 | **F. Anthony Naccarato**  
7 Lawrence Court  
Syosset, NY 11791 |
| **Jose Leonard (Alternate) (Pro Tem)**  
National Secretary-Treasurer  
American Maritime Officers  
601 S. Federal Highway  
Dania Beach, FL 33004 | **Edward Hanley**  
Vice President, Labor Relations  
Maersk Line Ltd.  
One Commercial Place, 20th Floor  
Norfolk, VA 23510 |
| **Joseph Gremelsbacker**  
National Vice President, Deep Sea  
American Maritime Officers  
601 S. Federal Highway  
Dania Beach, FL 33004 | **David Schultze**  
Manager, Fleet Human Resources  
Keystone Shipping Company  
One Bala Plaza  
Bala Cynwyd, PA 19004 |
| **Robert Kiefer**  
National Executive Vice President  
American Maritime Officers  
2 International Plaza  
Suite 422  
Philadelphia, PA 19113 | **Robert Rogers**  
Vice President, Human Resources  
Interocian American Shipping Corporation  
302 Harper Drive, Suite 200  
Moorestown, NJ 08057 |
| **John E. Clemons**  
National Vice President, Great Lakes  
American Maritime Officers  
One Maritime Plaza  
Third Floor  
Toledo, OH 43604 | **Norman Gauslow**  
Vice President, Labor Relations  
OSG America, Inc.  
302 Knights Run Avenue, Suite 1200  
Tampa, FL 33602 |
| **David Weathers**  
National Assistant Vice President  
American Maritime Officers  
2724 61st Street, Suite B  
PMB 192  
Galveston, TX 77551 | **Todd Johnson (Alternate)**  
President and Chief Executive Officer  
Pacific-Gulf Marine, Inc.  
401 Whitney Avenue, Suite 511  
Gretna, LA 70056 |
<table>
<thead>
<tr>
<th>UNION TRUSTEES</th>
<th>EMPLOYER TRUSTEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daniel Shea (Alternate)</td>
<td>Steve Demeroutis (Alternate)</td>
</tr>
<tr>
<td>National Assistant Vice President</td>
<td>Vice President, Labor Relations</td>
</tr>
<tr>
<td>American Maritime Officers</td>
<td>Crowley Maritime Corporation</td>
</tr>
<tr>
<td>1121 7th Street, Second Floor</td>
<td>9487 Regency Square Blvd.</td>
</tr>
<tr>
<td>Oakland, CA 94607</td>
<td>Jacksonville, FL 32225</td>
</tr>
<tr>
<td>Brian Krus (Alternate)</td>
<td></td>
</tr>
<tr>
<td>Senior National Vice President</td>
<td></td>
</tr>
<tr>
<td>American Maritime Officers</td>
<td></td>
</tr>
<tr>
<td>1 Maritime Plaza</td>
<td></td>
</tr>
<tr>
<td>Toledo, OH 43604</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B – AMO MEDICAL PLAN
PLAN DOCUMENT LOCATIONS

Copies of plan documents will be made available for review at the following locations upon prior written request to the AMO Plans or the AMO Union.

601 S. Federal Highway
Dania Beach, FL 33004
954-922-2221, or
800-362-0513

490 L’Enfant Plaza East, S.W.
Suite 7204
Washington, DC 20024
202-479-1166, or
800-362-0513 ext. 7001

2 West Dixie Highway
Dania Beach, FL 33004
954-920-9482, ext. 12, or
800-348-6515 ext. 12

1 Maritime Plaza
3rd Floor
Toledo, OH 43604
419-255-3940, or
800-221-9395

2724 61st Street
Suite B
Galveston, TX 77551
800-362-0513 ext. 2001

1121 7th Street
2nd Floor
Oakland, CA 94607
510-444-5301, or
800-362-0513 ext. 5001

2 International Plaza
Suite 422
Philadelphia, PA 19113
800-362-0513 ext. 4001 or 4002

463 Livingston Street
Suite 102
Norwood, NJ 07648
800-362-0513 ext. 3004
ADDENDUM TO THE
AMERICAN MARITIME OFFICERS
MEDICAL PLAN
SUMMARY PLAN DESCRIPTION

BENEFITS ADMINISTERED
BY THE PLAN OFFICE

January 1, 2012
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This addendum to the Summary Plan Description (SPD) of the AMO Medical Plan (the “Plan”) describes benefits offered under the Plan that are administered and paid by the Plan office (not UMR). Claims for benefits described under this addendum must be filed by you or the provider directly with the Plan office. These benefits consist of optical benefits, dental benefits, death benefits, accidental death and dismemberment (AD&D) benefits, scholarship benefits, and wage insurance benefits, as discussed further below.

This addendum is incorporated by reference into the SPD and all relevant provisions of the SPD apply. If there is a conflict between the SPD and this addendum with respect to the benefits described herein, the provisions of this addendum will govern.

CLAIM SUBMISSION

The following sets forth the procedure for filing claims for benefits described in this addendum.

REQUIRED DOCUMENTATION

Optical and Dental Benefits
A claim form specifying the services rendered from each provider and any other supporting documentation that may be requested must be submitted to the Plan office. An original itemized receipt is required when submitting a claim for dental benefits.

Other Benefits
An application for any other benefit discussed in this addendum must be submitted to the Plan office along with any supporting documentation that may be requested.

TIME FOR FILING CLAIMS

Claims for benefits described in this addendum must be received by the Plan office within 365 days following the date the charges are incurred. No Plan benefits will be paid for any claim not submitted to the Plan within this period. Claim forms are available from the Plan office and at www.amoplans.com.

CLAIM DETERMINATION

DISABILITY BENEFITS CLAIM (FOR MARITIME PARTICIPANTS ONLY)

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 any benefit other than a disability benefit, 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 AND APPEALS PROCEDURES**

Please refer to the applicable sections of the SPD.

**BENEFITS FOR ACTIVE PARTICIPANTS AND THEIR DEPENDENTS**

**OPTICAL BENEFITS**

**SCHEDULE OF BENEFITS – OPTICAL***

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>DEDUCTIBLES/CO-PAYMENTS/ CO-INSURANCE</th>
<th>VISIT/ DOLLAR LIMITATION</th>
<th>PRE-CERT REQD?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optical Benefit</td>
<td>No Deductible</td>
<td>$180 per person per calendar year</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No Co-payment</td>
<td>Maximum accumulation of $360 every 2 calendar years</td>
<td></td>
</tr>
<tr>
<td>Optical Benefit - Lasik Vision Correction Benefit</td>
<td>No Deductible</td>
<td>$600 per person per lifetime</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No Co-payment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Optical benefits are payable for any combination of any treatment of services relating to Lasik Vision Correction.

**EXCLUSIONS AND LIMITATIONS**

- Benefit limited to refractions, prescription 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.
DENTAL BENEFITS

SCHEDULE OF BENEFITS - DENTAL

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>DEDUCTIBLES/CO-PAYMENTS/CO-INSURANCE</th>
<th>AMO MEDICAL PLAN BENEFIT</th>
<th>VISIT/DOLLAR LIMITATION</th>
<th>PRE-CERT REQ'D?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Benefit</td>
<td>No Deductible</td>
<td>100% of first $500 of dental expenses</td>
<td>$2,000 maximum annual benefit per Active participant and eligible dependent per calendar year</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Not subject to Annual Medical Co-Insurance Maximum</td>
<td>50% of next $3,000 of dental expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No co-insurance for first $500 of dental expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% of next $3,000 of dental expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EXCLUSIONS AND LIMITATIONS

- 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;
EXCLUSIONS AND LIMITATIONS - Continued
- Dental work resulting from accidental injury.
- Services covered under Medical Benefits.
- Expenses in excess of the maximum benefits provided in Schedule of Dental Benefits.

BENEFITS FOR ELIGIBLE DEPENDENT CHILDREN OF ACTIVE PARTICIPANTS AND ELIGIBLE PENSIONERS
The following benefit is available to eligible dependent children of participants (active participants and pensioners).

SCHOLARSHIP BENEFIT (FOR PARTICIPANTS WITH DEEP SEA, GREAT LAKES, AND INLAND WATERS LEVEL BENEFITS ONLY)

SCHEDULE OF BENEFITS - SCHOLARSHIP

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>DEDUCTIBLES/CO-PAYMENTS/CO-INSURANCE</th>
<th>AMO MEDICAL PLAN BENEFIT</th>
<th>LIMITATION</th>
<th>PRE-CERT REQD?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scholarship Benefit</td>
<td>No Deductible</td>
<td>$3,000 per scholastic year</td>
<td>No more than four scholarships may be provided per Dependent child</td>
<td>No</td>
</tr>
</tbody>
</table>

ELIGIBILITY REQUIREMENTS
- Active participants must be eligible for medical benefits under the Plan both on the date the scholastic year starts and ends. An active participant must be employed by a company whose contributions to the 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 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 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 in the SPD except that a Dependent child who turns age 26 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 Plan provides all eligible participants with yearly scholarship benefits as provided in the schedule above 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 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**

**SCHEDULE OF BENEFITS – DEATH BENEFIT**

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>DEDUCTIBLES/CO-PAYMENTS/CO-INSURANCE</th>
<th>AMO MEDICAL PLAN BENEFIT</th>
<th>VISIT/ DOLLAR LIMITATION</th>
<th>PRE-CERT REQD?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Benefit</td>
<td>No Deductible</td>
<td>$50,000</td>
<td>Active Employees Only</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No Co-payment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SCHEDULE OF BENEFITS – AD&D (FOR PARTICIPANTS WITH DEEP SEA, GREAT LAKES, AND INLAND WATERS LEVEL BENEFITS ONLY)

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>DEDUCTIBLES/CO-PAYMENTS/CO-INSURANCE</th>
<th>AMO MEDICAL PLAN BENEFIT</th>
<th>VISIT/DOLLAR LIMITATION</th>
<th>PRE-CERT REQD?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Death &amp; Dismemberment Benefit</td>
<td>No Deductible No Co-payment</td>
<td>$25,000 or $50,000 depending on nature of loss</td>
<td>Eligible Active Employees Only</td>
<td>No</td>
</tr>
</tbody>
</table>

ELIGIBILITY REQUIREMENTS

- 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

- Accidental Death and Dismemberment Benefits are available only to participants and eligible pensioners with Deep Sea, Great Lakes, and Inland Waters level benefits.
- 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:

<table>
<thead>
<tr>
<th>Full amount of benefit will be payable for loss of:*</th>
<th>One-half of the full amount of benefit will be payable for loss of:*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Life • Both hands • Both feet • One hand and one foot</td>
<td>• Sight of both eyes • One hand and sight of one eye • One foot and sight of one eye</td>
</tr>
<tr>
<td>• One hand • One foot • Sight of one eye</td>
<td></td>
</tr>
</tbody>
</table>

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

SCHEDULE OF BENEFITS - DISABILITY

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>DEDUCTIBLES/CO-PAYMENTS/CO-INSURANCE</th>
<th>AMO MEDICAL PLAN BENEFIT</th>
<th>VISIT/ DOLLAR LIMITATION</th>
<th>PRE-CERT REQD?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Benefit</td>
<td>No Deductible</td>
<td>$50 per week up to 39 weeks</td>
<td>Active Employees Only</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No Co-payment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 the above schedule.

**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).
- 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).
- Where a participant who is eligible for benefits under the Plan is disabled while working on a non-signatory vessel, no Disability Benefits shall be payable under the 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 the schedule above 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 PARTICIPANTS ONLY)

If a covered participant is unable to collect any earned and unpaid 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 ELIGIBLE PENSIONERS AND THEIR DEPENDENTS

For pensioners who are eligible for coverage under the Plan, the following benefits are provided:

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 who retired with Deep Sea, Great Lakes, or Inland Waters level benefits and who are receiving pensioner benefits under the 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/or eligible dependents will be entitled to medical coverage only for the remaining period of such 60-month payout. A spouse is considered to be a surviving spouse only if the pensioner and spouse were married on the pension effective date. The Trustees reserve the right to amend, modify or terminate, in whole or in part, survivor benefits.
American Maritime Officers Medical Plan- Prescription Drug Benefit

Below is a summary of prescription drug benefits for American Maritime Officers Medical Plan. Should you have additional questions about the prescription drug benefit, please start by visiting the Envision Rx website @ www.envisionrx.com or call their Customer Service department toll free at 1-800-361-4542. Envision representatives are available 24/7 to assist with your prescription questions.

**Deductible**

You have an annual deductible of $100.00 for an Individual or $200.00 per family that must be paid by you before your co-payments go into effect.

**Your Co-payments**

<table>
<thead>
<tr>
<th></th>
<th>Retail * 30 Day Supply</th>
<th>Retail * 90 Day Supply-Maintenance Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic Prescription Drugs</strong></td>
<td>$10.00 or 20% whichever is greater</td>
<td>$10.00 or 20% whichever is greater</td>
</tr>
<tr>
<td><strong>Brand Prescription Drugs</strong></td>
<td>$10.00 or 20% whichever is greater</td>
<td>$10.00 or 20% whichever is greater</td>
</tr>
<tr>
<td><strong>Brand Prescription Drugs with a generic available</strong></td>
<td>$10.00 or 20% whichever is greater plus the difference between the brand and the generic</td>
<td>$10.00 or 20% whichever is greater plus the difference between the brand and the generic</td>
</tr>
</tbody>
</table>

* For a complete list of the 65,000 participating pharmacies, please visit our website @ www.envisionrx.com (under the resource tools sections) or call us toll free at 1-800-361-4542.

**Covered Medications**

- Federal Legend Drugs
- Insulin
- Urine Test Strips
- ADHD drugs- up to age 24 then requires a P.A.
- Prenatal Vitamins – for members and spouses ONLY
- Blood Sugar Diagnostics
- Epi-Pen
- Oral Contraceptives
- Compounds
- Smoking Deter.-$500/lifetime
- Differin-up to age 24
Non-Covered Medications

- Rogaine
- Nutrients
- Weight Loss Drugs
- Medications which have not been approved by the Federal Drug Administration (FDA)

Mandatory Generic Medications

Generic and brand medications must meet the same standards set by the U.S. Food and Drug Administration for safety and effectiveness. You are encouraged to work with your doctor to determine which medication options are best for you.

If the member or the physician wishes to use a brand name drug when a U.S. Food and Drug Administration determined therapeutically equivalent (“AA” or “AB” rated) generic is available, the member will pay the difference in the brand name and generic medication price, plus your co-payment.

Drugs requiring Prior Authorization and Quantity Limits

Some medications will require a prior authorization, which is clarification by your prescribing physician for certain medications. Please refer to the chart below for a list of drug classifications that require a prior authorization. If you have questions about the medications that require a prior authorization, call the Envision Rx Options Customer Service Help Desk at 1-800-361-4542. They will fax a medical necessity form to your physician and Envisions Clinical Staff will determine if the medication will be approved for your medical condition.

- Injectable Drugs
- Prenatal Vitamins
- Specialty Medications

Quantity Limits

Quantity limits are used to manage the quantity of medications available to any member that may be potentially harmful, subject to abuse, is not consistent with the standard of care in today’s medical practice, or other reasons. Members may obtain prior authorization to receive such medications at the higher than normal dosage when medically necessary. The chart below lists medications subject to quantity limits.
<table>
<thead>
<tr>
<th>Brand Drug Name</th>
<th>Generic Drug Name</th>
<th>Drug Class</th>
<th>Retail quantity</th>
<th>Retail 90 Day Supply Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imitrex 100mg tabs</td>
<td>Sumatriptan</td>
<td>Migraine</td>
<td>9 tabs</td>
<td>27 tabs</td>
</tr>
<tr>
<td>Imitrex 25mg tabs</td>
<td>Sumatriptan</td>
<td>Migraine</td>
<td>9 tabs</td>
<td>27 tabs</td>
</tr>
<tr>
<td>Imitrex 50mg tabs</td>
<td>Sumatriptan</td>
<td>Migraine</td>
<td>9 tabs</td>
<td>27 tabs</td>
</tr>
<tr>
<td>Imitrex 6mg/.05ml Injectable Kit</td>
<td>Sumatriptan</td>
<td>Migraine</td>
<td>2 kits (4 doses)</td>
<td>6 kits (12 doses)</td>
</tr>
<tr>
<td>Imitrex 6mg/.05ml Injectable Vial</td>
<td>Sumatriptan</td>
<td>Migraine</td>
<td>5 vials (5 doses) 2.5ml</td>
<td>15 vials</td>
</tr>
<tr>
<td>Imitrex NS 20mg/6ml</td>
<td>Sumatriptan</td>
<td>Migraine</td>
<td>1 bx (6 doses) 6ml</td>
<td>3 boxes (18ml)</td>
</tr>
<tr>
<td>Imitrex NS 5mg</td>
<td>Sumatriptan</td>
<td>Migraine</td>
<td>3 bx (18 doses) 18ml</td>
<td>6 bx (54 doses) 54ml</td>
</tr>
</tbody>
</table>

**Retail Prescriptions**

To receive a prescription at a retail pharmacy you must go to a network pharmacy and present your prescription card. To access the Envision Rx Options Pharmacy Locator, please visit [www.envisionrx.com](http://www.envisionrx.com).

**Lost Identification Card**

Your prescription card is sent from Envision Rx Options. Should you need your covered prescriptions immediately, please present this information to the pharmacist:

**BIN:** 009893  
**PCN:** ROIRX

Have the pharmacist call to verify coverage. Envision Rx Options Pharmacy Helpdesk number is 1-800-361-4542. You may also call Envision Rx Options Helpdesk to request a new card 1-800-361-4542.

**Additional Website information**

Envision Rx Options is also pleased to announce that our newly enhanced website ([www.envisionrx.com](http://www.envisionrx.com)) is now available for all members to utilize. These enhancements will allow current members to register online and view benefit information quickly and easily.

Online registration takes only a few moments of your time and will allow you access to items such as a Participating Pharmacy Locator, an overview of your plan and benefits, drug coverage and pricing (including co-pays for mail order and retail), Prescription History and Direct Member Reimbursement Forms.

Please use the following steps below to register online:
Go to www.envisionrx.com website and click on the “Not Registered? Click here to enroll” link that is located on the left side of the page.

1. To create your account, enter all the required information and press the “Register” button. (Please note the e-mail address used to create your account will become your User Name when you log on.)
2. Once your account has been created successfully, you will be offered a link to log on and view your information. An e-mail will also be sent to you in order to confirm your newly created account.
3. Once you have created an account and log on as a registered member, you will be provided with a “Prescription Plan Overview” describing your benefit. On the left side of this page, you are also able to enter in the medications that you use in order to find the applicable co-pay.
4. Other tools can be found by clicking on the blue “Members” link located at the top of the page. These options include:
   - **Plan Overview and Benefits**: This link will provide an overall look at your prescription benefit.
   - **Drug Coverage & Pricing**: This link will allow you to type in your specific medication names and obtain retail co-pays.
   - **Direct Member Reimbursement**: This link will allow you to print a Direct Member Reimbursement form and instructions on how a Direct Member Reimbursement can be submitted.
   - **Prescription History**: This link will allow you to select specific dates and obtain a prescription history for that timeframe (Please note, the last six months of your prescription history is available for viewing, the claims history data is available for viewing five days after the prescription was filled at your retail mail order service pharmacy).
   - **Manage Your Account**: This link will allow you to edit your personal information, user name or password.
INTRODUCTION TO SUMMARY OF BENEFITS
Thank you for your interest in EnvisionRx Plus Silver (PDP). Our plan is offered by ENVISION INSURANCE COMPANY/EnvisionRx Plus, a Medicare Prescription Drug Plan that contracts with the Federal government.

This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call EnvisionRx Plus Silver (PDP) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR MEDICARE PRESCRIPTION DRUG COVERAGE
As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare Prescription Drug Plan, like EnvisionRx Plus Silver (PDP). Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You make the choice.

HOW CAN I COMPARE MY OPTIONS?
The charts in this booklet list some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by EnvisionRx Plus Silver (PDP) to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

WHERE IS ENVISIONRX PLUS SILVER (PDP) AVAILABLE?
The service area for this plan includes Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming. (Available in all 50 states.) You must live in one of these areas to join this plan. If you move out of the state or county where you currently live to a state listed above, you must call Customer Service to update your information. If you don’t, you may be disenrolled from EnvisionRx Plus Silver. If you move to a state not listed above, please call Customer Service to find out if Envision Insurance Company has a plan in your new state or county.

WHO IS ELIGIBLE TO JOIN?
You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B and live in the service area.

If you are enrolled in an MA coordinated care (HMO or PPO) plan or an MA PFFS plan that includes Medicare prescription drugs, you may not enroll in a PDP unless you disenroll from the HMO, PPO or MA PFFS plan. Enrollees in a private fee-for-service plan (PFFS) that does not provide Medicare prescription drug coverage, or an MA Medical Savings Account (MSA) plan, may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP.

WHERE CAN I GET MY PRESCRIPTIONS?
EnvisionRx Plus Silver (PDP) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.
The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or visit us at www.envisionrxplus.com. Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

**EnvisionRx Plus Silver** (PDP) does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

**EnvisionRx Plus Silver** (PDP) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at www.envisionrxplus.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

WHAT SHOULD I DO IF I HAVE OTHER INSURANCE IN ADDITION TO MEDICARE?

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap supplement policy, your Medigap Issuer will remove the prescription drug coverage portion of your policy. Call your Medigap Issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join **EnvisionRx Plus Silver** (PDP). Get this information before you decide to enroll in this plan.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

* 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare You.
* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
* Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Prescription Drug Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with the Medicare Prescription Drug Plan Program. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also Medicare may decide to end a contract with a plan. Even if your Medicare Prescription Drug Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of **EnvisionRx Plus Silver** (PDP), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask...
us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?
A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact EnvisionRx Plus Silver (PDP) for more details.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?
The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call EnvisionRx Plus for more information about EnvisionRx Plus Silver (PDP).
Visit us at www.EnvisionRxPlus.com or, call us:
Customer Service Hours:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Open 24 Hours Eastern
Current members should call toll-free (866)-250-2005. (TTY/TDD 711)
Prospective members should call toll-free (866)-250-2005. (TTY/TDD 711)
Current members should call locally (866)-250-2005. (TTY/TDD 711)
Prospective members should call locally (866)-250-2005. (TTY/TDD 711)
For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
Or, visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

If you have any questions about this plan's benefits or costs, please contact EnvisionRx Plus for details.
### SUMMARY OF BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Original Medicare</th>
<th>EnvisionRx Plus Silver (PDP)</th>
</tr>
</thead>
</table>
| Outpatient Prescription Drugs | Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage. | **Drugs covered under Medicare Part D**

**General**

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at [www.envisionrxplus.com](http://www.envisionrxplus.com) on the web.

Different out-of-pocket costs may apply for people who
- have limited incomes,
- live in long term care facilities; or
- have access to Indian/Tribal/Urban (Indian Health Service) providers.

Your premiums are paid by your group.

Most people will pay their Part D premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by both you and a Part D plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from **EnvisionRx Plus Silver** (PDP) for certain drugs.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare...
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<tr>
<td>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</td>
<td></td>
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</tr>
<tr>
<td><strong>In-Network</strong></td>
<td>$100 annual deductible.</td>
<td></td>
</tr>
<tr>
<td><strong>Retail Pharmacy</strong></td>
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<tr>
<td>Tier 1: Preferred Generic Drugs</td>
<td>- Greater of $10 or 20% copay for a one-month (30-day) supply of drugs in this tier</td>
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<td>Tier 2: Preferred Brand Drugs</td>
<td>- Greater of $10 or 20% copay for a one-month (30-day) supply of drugs in this tier</td>
<td>- Greater of $10 or 20% copay for a three-month (90-day) supply of drugs in this tier</td>
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<tr>
<td>Tier 3: Non-Preferred Brand Drugs</td>
<td>- Greater of $10 or 20% coinsurance for a one-month (30-day) supply of drugs in this tier</td>
<td>- Greater of $10 or 20% coinsurance for a three-month (90-day) supply of drugs in this tier</td>
</tr>
<tr>
<td>Tier 4: Specialty Tier Drugs</td>
<td>- Greater of $10 or 20% coinsurance for a one-month (30-day) supply of drugs in this tier</td>
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<td><strong>Long Term Care Pharmacy</strong></td>
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<tr>
<td>Tier 1: Preferred Generic Drugs</td>
<td>- Greater of $10 or 20% copay for a one-month (31-day) supply of drugs in this tier</td>
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<td><strong>Catastrophic Coverage</strong></td>
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<td>After your yearly out-of-pocket drug costs reach $4,700, you pay the greater of: 5% coinsurance, or $2.60 copay for generic (including brand drugs treated as generic) and $6.50 copay for all other drugs.</td>
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<tr>
<td><strong>Out-of-Network</strong></td>
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<tr>
<td>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from EnvisionRxPlus Silver (PDP). You can get drugs the following way: one-month (30-day) supply</td>
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<td><strong>Out-of-Network Initial Coverage</strong></td>
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<td>After you pay your yearly deductible, you will be reimbursed up to 75% of the actual cost for drugs purchased out-of-network until your total yearly drug costs reach $2,930.</td>
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<tr>
<td><strong>Additional Out-of-Network Coverage Gap</strong></td>
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<td>You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,700. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,700.</td>
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<tr>
<td><strong>Out-of-Network Catastrophic Coverage</strong></td>
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<td>After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: 5% coinsurance, or $2.60 copay for generic (including brand drugs treated as generic) and $6.50 copay for all other drugs.</td>
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