

SUP WELFARE PLAN, INC.

SUMMARY PLAN DESCRIPTION

For Active Participants and Pensioners

JANUARY 1, 2016

SUP Welfare Plan, Inc.

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Dear Participant:

We are pleased to present this booklet describing the benefits provided by the SUP Welfare Plan. The Plan was established in accordance with Collective Bargaining Agreements between the Sailors' Union of the Pacific and participating employers.

This booklet furnishes a brief description of the benefits to which you and your family are entitled, the rules governing these benefits, and the procedures that should be followed when making a claim. This booklet includes certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974. Medical and dental benefits that are insured are described in separate booklets, insurance policies, or Evidence of Coverage and are incorporated by reference into this document. This document, including all documents incorporated by reference, is intended to meet the Summary Plan Description ("SPD") requirements of the Employee Retirement Income Security Act of 1974 ("ERISA").

We urge you and your family to read this booklet thoroughly so that you will be familiar with the benefits of the Plan. In the event of a conflict between the information provided in this SPD and the terms of the Plan document, any insurance policy, or any Evidence of Coverage, the terms of the Plan document, insurance policy, or Certificate of Coverage shall govern, unless superseded by applicable law.

From time to time, the Board of Trustees may find it advisable to change the benefit provisions of the Plan. In the event this occurs, you will be advised of any change by first class mail. **To ensure notification, you must provide the Plan Office with your current address in writing.**

Only the full Board of Trustees is authorized to interpret the Plan benefits described in this booklet, and no individual Trustee, Union representative, Employer representative or Employee of the Plan is authorized to interpret this Plan on behalf of the Board or to act as an agent of the Board. With respect to benefits that are provided pursuant to an insurance or HMO contract, the Trustees have delegated the authority to determine and pay claims for benefits and interpret the terms of such contract for the purpose of determining such claims to the applicable insurance carrier or HMO. Except with respect to benefits that are insured, the Trustees have authorized the Administrator to respond in writing to Plan Participants regarding the administration of the Plan. As a convenience to Participants, the Administrator will provide oral answers regarding coverage on an informal basis. However, no such oral communication is binding upon the Board of Trustees. The Board of Trustees has delegated

The Trustees in their sole discretion may amend the Plan by a majority vote of the Trustees. Except with respect to the determination and payment of insured benefits, the Trustees will have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply, and interpret the Plan and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan as follows:

1. To formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;
2. To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
3. To resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents; and
4. To process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the Trustees with respect to any matter arising under the Plan and any other Plan documents will be final and binding on all parties.

Sincerely yours,

Board of Trustees

Note: Whenever the masculine gender is used in this booklet, it will be deemed to include the feminine gender as well.

INFORMATION REQUIRED BY ERISA

PLAN NAME

SUP Welfare Plan, Inc.

PLAN SPONSOR

The Plan Sponsor is the Board of Trustees of the SUP Welfare Plan, Inc.

TRUST IDENTIFICATION NUMBER

The Trust's identification number is 94-1243666

PLAN NUMBER

This Plan has been assigned number 502

TYPE OF PLAN

This Plan is a welfare Plan providing health benefits, such as medical, prescription drug, dental, vision, and death benefits to eligible active employees. The Plan also provides medical, prescription drug and dental benefits to dependents of eligible active employees. Pensioners and spouses are eligible for reimbursement of certain out of pocket medical, prescription drug, dental and vision expenses incurred.

FISCAL YEAR

The Plan's fiscal year is a twelve-month period beginning on August 1 and ending July 31 of each year

PLAN ADMINISTRATOR

Michelle Chang, Administrator
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San Francisco, CA 94107
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Scottsdale, AZ 85266

BOARD OF TRUSTEES

The Board of Trustees is responsible for the operation of the Plan and is made up of an equal number of Trustees appointed by the Participating Employers (or their duly appointed representatives) and Trustees appointed by the Union. The names and addresses of these Trustees are shown on the prior page.

AGENT FOR SERVICE OF LEGAL PROCESS

The Administrator is the designated agent of the Plan for service of legal process. Legal process may also be served on a Trustee.

ADMINISTRATION OF THE PLAN

The administration of the Plan is by an Administrator and the Plan Office staff that is retained by the Board of Trustees and compensated by the Plan at the direction of the Board of Trustees. The name, address and phone number of the Administrator is shown on the prior page.

The medical, drug, and dental benefits described in this booklet are self-funded and are not provided through prepaid providers or pursuant to insurance contracts. All claims presented by Plan Participants are computed and reimbursed by the Administrator. Benefits that are insured are administered pursuant to the group insurance or HMO contract between the Board of Trustees and the insurance carrier or HMO.

In accordance with prudent management standards, the following professionals are retained by the Board of Trustees to assist them in the operation of the Plan:

1. Consultants, to assist the Board of Trustees in technical matters relating to the operations of the Plan, such as the design of benefit programs and eligibility provisions, analysis of emerging loss experience and projections of anticipated benefit costs, preparation of specifications for competitive bids, etc.;
2. Certified Public Accountant, responsible to the Board of Trustees for auditing the records of the Plan;
3. Legal Counsel.
4. Plan Administrator to assist the Board of Trustees in the day to day administration of the Plan Office and administration of benefit programs and eligibility provisions of the Plan.

The Plan's requirements with respect to eligibility for participation and benefits are found in this booklet. Benefits for Pensioners are also published in this booklet.

COLLECTIVE BARGAINING AGREEMENT

The Plan is maintained pursuant to Collective Bargaining Agreements between the Sailors' Union of the Pacific and various Participating Employers. A copy of the applicable Collective Bargaining Agreement will be provided to you upon written request to the Plan Office or you may examine a copy at the Plan Office during normal business hours.

ELIGIBILITY

The Plan's requirements with respect to eligibility for participation and benefits are found in this booklet. Benefits for Pensioners are also published in this booklet. Eligibility for benefits is described in this Plan Booklet beginning on Page 16 and beginning on Page 38.

CIRCUMSTANCES WHICH MAY RESULT IN LOSS OF BENEFITS

The circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of any benefits are stated in detail on pages 16-20, 38-41, and 42. The procedures for filing a claim or appealing a denial vary according to the benefit. Please refer to pages 42-51.

SOURCE OF CONTRIBUTIONS AND FUNDING MEDIUM

The Plan is financed by Participating Employer contributions pursuant to the Collective Bargaining Agreements. A supplemental source of financing is interest income earned on the investment of reserve funds, employee self-payments for certain health plans and voluntary contributions of Participants to retain eligibility. Plan contributions are deposited in the SUP Welfare Plan, Inc. which is maintained by the Board of Trustees.

It is recognized that the payments provided for in the Plan can be reimbursed only to the extent that the Plan has available adequate resources for such payments. No contributing Employer has liability, directly or indirectly, to provide the benefits established hereunder beyond the obligation of the contributing Employer to make contributions as stipulated in its Collective Bargaining Agreement. In the event that at any time the Plan does not have sufficient assets to permit continued payments hereunder, nothing contained in the Plan or this Summary Plan Description (SPD) will be construed as obligating any contributing Employer to make payments or contributions (other than the contributions for which the contributing Employer may be obligated by its Collective Bargaining Agreement) in order to provide for the payments established hereunder. Likewise, there is no liability upon the Board of Trustees, individually or collectively, or upon any Employer, any Signatory Association, the Union, any Local Union or any other person or entity of any kind to provide the benefits established hereunder if the Plan does not have sufficient assets to make such payments.

None of the benefits described in this booklet except those provided by the prepaid providers are insured by any contract of insurance, and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts collected and available through the Plan for such purposes.

INSURERS AND SERVICE PROVIDERS

The SUP Welfare Plan, Inc. contracts with insurers and service providers to provide medical, prescription drug and dental benefits and an Employee Assistance Program to Active Employees and Dependents. For the Active Employee, the Trust self-funds vision benefits, death and burial benefits, hearing aid benefits and alcohol/substance abuse rehabilitation benefits, as well as self-funds a direct reimbursement program for the Employee's out of pocket expenses not covered by the pre-paid or PPO insurance carrier. All benefits provided to Pensioners and their Dependents are self-funded and are described starting on Page 38. The insured benefits are described in separate Evidences of Coverage/Certificates of Coverage, or in other booklets, all of which are provided free of charge as separate documents. These booklets describe the terms and conditions governing the provision of such benefits by such insurer or HMO and include descriptions of: (1) the benefits available (e.g., benefit amounts, services, treatment, exclusions and limitations, etc.); (2) cost-sharing provisions (including co-payments, deductibles, and premiums); (3) benefit maximums (including annual and/or lifetime limits or caps); (4) information regarding the provider network and whether out-of-network coverage is available with respect to the dental and vision benefit programs; (5) any preauthorization or utilization review requirements under the dental and vision benefit programs; (6) claims and appeals procedure; (7) coordination of benefits provisions; and (8) any third party reimbursement or subrogation provisions. All benefits are subject to the terms and conditions of the Plan as provided in these official Plan documents.

The addresses for the current insurers and service providers are as follows:

Blue Cross-Blue Shield of Louisiana

3501 N. Causeway Blvd.

Suite 500

Metairie, LA 70009

Provides prepaid medical, drug and vision benefits to participants enrolled in Blue Cross with guaranteed payment of these benefits.

Group Health Cooperative of Puget Sound

1730 Minor Avenue

P.O. Box 34750

Seattle, WA 98124-1750

Provides prepaid medical and prescription drug benefits to participants enrolled in GHC, with guaranteed payment of those benefits.

Health Net of California

155 Grand Avenue

Oakland, CA 94612

Provides prepaid medical and prescription drug benefits with guaranteed payment of these benefits to participants enrolled in the Health Net HMO plan. Provides insured medical and prescription drug benefits with guaranteed payment of these benefits to participants enrolled in the Health Net PPO Plans.

Kaiser Foundation Health Plan, Inc.

Northern California Region

1800 Harrison, 9th Floor

Oakland, CA 94612-3412

Provides prepaid medical, drug and vision benefits to participants enrolled in Kaiser, with guaranteed payment of these benefits.

Kaiser Foundation Health Plan, Inc.

Southern California Region

Walnut Center

Pasadena, CA 91188

Provides prepaid medical and prescription drug benefits to participants enrolled in Kaiser; with guaranteed payment of these benefits.

Kaiser Foundation Health Plan, Inc.

Hawaii Region

3288 Moanalua Road

Honolulu, HI 96819

Provides prepaid medical, prescription drug and dental benefits with guaranteed payment of these benefits to participants enrolled in the Kaiser plan.

Kaiser Foundation Health Plan of the NW

Kaiser Permanente Building

500 NE Multnomah Street

Suite 100

Portland, OR 97232-2099

Provides prepaid medical, prescription drug and dental benefits to participants enrolled in Kaiser, with guaranteed payments of these benefits.

Dental Health Services (DHS)

Northlake Plaza

936 North 34th Street

Suite 208

Seattle, WA 98103

Provides prepaid dental benefits to participants enrolled in DHS, with guaranteed payment of these benefits.

Delta Care

12898 Towne Center Drive

Cerritos, CA 90703

Provides prepaid dental benefits to participants enrolled in Delta Dental PMI, with guaranteed payment of these benefits.

Dina Dental Plan—New Orleans

P.O. Box 40017

Baton Rouge, LA 70835

Provides prepaid dental benefits to participants enrolled in Dina, with guaranteed payment of these benefits.

United HealthCare Dental

2300 Clayton Rd. #1000

Concord, CA 94520

Provides prepaid dental benefits to participants enrolled in United HealthCare, with guaranteed payment of these benefits

AIG Benefit Solutions

3600 Route 66

Neptune, NJ 07753

Provides insured dental benefits to participants enrolled in AIG, with guaranteed payment of these benefits

Human Behavior Associates, Inc. (HBS)

1350 Hayes Street, Suite B-100

Benicia, CA 94510

Administers the Employee Assistance Program for eligible participants; with guaranteed payment of the benefit.

CLAIMS AND APPEALS PROCEDURES

The procedures for filing a claim or appealing a denial vary according to the benefit. Please refer to pages 42-51 for a description of the procedures applicable to the Plan's self-funded benefits and refer to your Evidence of Coverage or Certificate of Coverage for a description of the procedures applicable to the Plan's insured benefits.

YOUR ERISA RIGHTS

As a Participant in the SUP Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Office, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a Summary of the Plan's Annual Financial Report. The Plan Administrator is required by law to furnish each Participant with a copy of the 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.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who create your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your

union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in Federal Court. In such case, the Court may require the Plan Administrator to provide the materials and pay up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The Court will decide who should pay court costs and legal fees. If you are successful, the Court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

The northern California regional office of the Pension and Welfare Benefits Administration is located at 71 Stevenson Street, Suite 915, P.O. Box 190250, San Francisco, CA 94119-0250.

OTHER IMPORTANT PROVISIONS

SPECIAL RIGHTS UPON CHILDBIRTH

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable). In any case, plans may not, under federal law, require that the provider obtain authorization from the group health plan or health insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SPECIAL RIGHTS CONCERNING MASTECTOMY COVERAGE

Under federal law, group health plans that provide coverage for mastectomies are also required to provide coverage for reconstructive surgery and prostheses following mastectomies. Specifically, the law mandates that a participant or eligible beneficiary who is receiving benefits for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and is subject to the same annual deductible, coinsurance and/or co-payment provisions otherwise applicable under the Plan. If you have questions concerning your coverage, please call the SUP Welfare Plan Administrator at (415) 778-5490.

CONTINUED COVERAGE WHILE IN UNIFORMED SERVICE

If an Eligible Employee performs service in the Uniformed Services of the United States, federal law provides certain rights to continued coverage under this Plan. An Eligible Employee may choose to continue coverage for up to a maximum of 24 months from the date that service commences.

The terms "Uniformed Services of the United States" and/or "Uniformed Services" means the Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If an Employee (and his or her eligible Dependents) is eligible for benefits as of the date of entry into the Uniformed Services, and the Employee's absence is due to a Uniformed Services leave of **31 days or less** and the Employee's Contributing Employer submits a contribution to the Plan on behalf of the Employee, coverage will be continued at no cost to the Employee. The Employee will be credited with hours necessary to keep coverage in effect as if the Employee had worked in covered employment with a Contributing Employer during the period of service.

If an Eligible Employee (and his or her eligible Dependents) is eligible for benefits as of the date of entry into the Uniformed Services of the United States, and the Employee's absence is due to a uniformed services leave of 31 days or more, the Employee or eligible dependent(s) may elect to continue coverage by: (1) using available hours in their hour bank account, or (2) self-payment under the provisions of the

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). An Employee electing to continue coverage need not use his/her hour bank and may always pay the required premium and preserve the hour bank account, but if he/she chooses to use his/her hour bank to pay USERRA premiums, the portion of the hour bank that is used will not be re-credited to the employee upon reinstatement.

A premium for continuation coverage under USERRA will be in an amount established by the Trust. Such premium shall be payable in monthly installments. The maximum length of USERRA Continuation Coverage is the lesser of:

- 24 months beginning on the day that the Uniformed Services leave commences; or
- a period ending on the day after the Eligible employee fails to return to employment within the time allowed by USERRA.

If non-service related health care expenses are incurred by the Employee or Dependents during a period of Uniformed Services leave, and those expenses are submitted to the Plan and benefits are paid by the Plan, the employee will be deemed to have chosen continued coverage for the month(s) beginning when the Employee entered Uniformed Service leave through the last month in which those health care expenses were incurred. In this case, available hours will be deducted from the Employee's hour bank account to provide eligibility to the extent possible.

Reinstatement of Eligibility following Uniformed Service

If an Employee was eligible for benefits on the date of entry into the Uniformed Services and upon completion of service the Employee notifies the Employer of his or her intent to return to employment as specified in USERRA, the employee's eligibility will pick up as it was the day before the Employee entered into Uniformed Services.

The Plan pays no benefits for conditions incurred or aggravated during performance of duties in the Uniformed Services.

If there is any conflict between these provisions and USERRA, the minimum requirements of USERRA shall govern.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 (FMLA) provides that in certain situations an Eligible Employee is entitled to take up to 12 workweeks of unpaid leave during any 12-month period (or 26 workweeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent, or next of kin (military caregiver leave), and that in such situations the Contributing Employer is required to continue coverage for the Employee. **Determination as to whether a leave of absence is an FMLA leave shall be made by the Contributing Employer, and is subject to review by the Board of Trustees.** If requested, and employee must submit proof acceptable to the Trust that the leave is in accordance with FMLA provisions.

If an Employee becomes eligible for both: (a) FMLA coverage due to the Employee's own disability, and (b) this Plan's 12-month *Special Extension for Total Disability*, continuation of eligibility will run concurrently until the FMLA leave is exhausted, then the available balance of *Special Extension for Total Disability* will be applied. Continuation of eligibility under FMLA is concurrent with all other continuation options except for COBRA; an employee is eligible to elect COBRA Continuation Coverage as of the day FMLA coverage ceases.

Continuation of coverage under FMLA ends on the earliest of:

- The day the Employee returns to work;

- The day the employee notifies his or her employer that he or she is not returning to work;
- The day coverage under the Plan would otherwise end (i.e., Plan maximum has been paid); or
- The day after coverage has been continued under FMLA for 12 (or 26) weeks.

Employees should contact their Employer to find out more about Family and Medical Leave and the terms on which an Employee may be entitled to it.

If there is any conflict between these provisions and FMLA, the minimum FMLA provisions shall govern.

Grandfathered Group Health Plans

The Plan's Board of Trustees has concluded that all of the Plan's health plan options, other than the Health Net HMO and Health Net PPO options as of October 1, 2015 are "grandfathered health plans" 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 certain lifetime limits on benefits.

Although those plans are "grandfathered health plans", you should know that the Plan provides health coverage benefits beyond the "basic" level of benefits and has long maintained many consumer protections now required under the Affordable Care Act. For example, the Plan has always prohibited rescissions of coverage due to a member's health condition as well as exclusions for pre-existing conditions for children and adults. There is also no "waiting period" for benefit eligibility once a member attains initial coverage based on required work hours. Nor does the Plan discriminate in favor of certain members based on compensation, age, gender or health status.

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 plan administrator at (415) 778-5490. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (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.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

NOTICE OF PRIVACY PRACTICES

1. Permitted Uses and Disclosures of PHI

This Plan with respect to self-funded group health plan benefits only and its Business Associates will use and disclose PHI without your authorization for purposes of treatment, payment and health care operations, but only the minimum amount of PHI necessary to accomplish these activities. Treatment includes but is not limited to the provision, coordination or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, adjudication of health benefit claims (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

2. Required Uses and Disclosures of PHI

This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of U.S. Department of Health and Human Services ("HHS") and its Office of Civil Rights ("OCR") or other authorized government organizations to investigate or determine this Plan's compliance with the Privacy Rule.

3. Agreed to Uses and Disclosures of PHI by You after an Opportunity to Agree or Disagree to the Disclosure

This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend's involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected.

4. Allowed Uses and Disclosures of PHI For Which Authorization or Opportunity to Object is Not Required

This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker's compensation programs and correctional facilities. These uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Plan Office.

5. Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

- You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a

request. If this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction.

- You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must accommodate such a request if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a request form to receive communications of PHI by alternative means or at alternative locations.
- You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for this Plan or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a request form to access PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. This Plan may charge a reasonable fee for the costs of copying. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or the HHS or its OCR.
- You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a request form to amend PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.
- You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for the six-year period preceding the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment or health care operations or made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures pursuant to an authorization request or disclosures made prior to the compliance date of the Privacy Rule. You will be required to complete a request form to obtain an accounting of PHI disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the account will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

6. Access by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with limited health care power of attorney regarding specific treatment, such as use of artificial life support, is your representative

only with respect to PHI that relates to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

Proof of such authority may take the form of a notarized power of attorney for health care purposes (general, durable or health care power of attorney), a court order of appointment as your conservator or guardian, an individual who is the parent, guardian or other person acting in loco parentis with legal authority to make health care decisions on behalf of a minor child, or an executor of the estate, next of kin, or other family member on behalf of a decedent.

This Plan retains discretion to deny a personal representative access to PHI if this Plan reasonably believes that you have been or may be subjected to domestic violence, abuse, or neglect by the personal representative or that treating a person as your personal representative could endanger you. This also applies to personal representatives of minors. Also, there are limited circumstances under state and other applicable laws when the parent is not the personal representative with respect to a minor child's health care information.

7. This Plan's Duties

In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Plan Office has designated this group of employees to include all employees dealing with the Trust. The employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan is required by law to provide you with its Notice of Privacy Practices ("Notice") by April 14, 2003, and thereafter, upon request. Also, the Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

This Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures to or requests by a health care provider for treatment purposes, disclosures made to you, uses or disclosures pursuant to your authorization, disclosures made to HHS or its OCR for enforcement purposes, uses or disclosures that are required by law, and uses or disclosures that are required for this Plan's compliance with HIPAA's Administration Simplification Rules.

8. Miscellaneous

This Plan may disclose de-identified health information. Health information is considered de-identified if it does not identify you and there is no reasonable basis to believe the information can be used to identify you, such as your name and Social Security Number.

This Plan may disclose summary health information to the Board of Trustees or a Business Associate. Summary health information is PHI, which includes claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.

This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages its use or purchase. However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information

describing the participating providers in its provider network(s), and the benefits provided under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

9. Duties of the Board of Trustees With Respect to PHI

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended this Plan and signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices for Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Plan Office.

10. Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Fund Administrator or the Board of Trustees. All complaints must be in writing and sent to the privacy officer at the address listed below. ***We may not retaliate against you or penalize you for filing a complaint.***

Michelle Chang, Administrator
SUP Welfare Plan, Inc.
730 Harrison Street, Suite 415
San Francisco, CA 94107
(415) 778-5490

This notice is subject to change from time to time in order to comply with federal regulations. Whenever a material change is made, you will promptly be notified.

SUMMARY OF BENEFITS

The following is a brief summary; complete details are provided later on in this booklet.

ACTIVE EMPLOYEE BENEFITS

BENEFIT	DESCRIPTION
PUBLIC HEALTH REPLACEMENT PROGRAM MEDICAL AND DENTAL BENEFITS	<p>Medical and Dental benefits provided through contracts with HMOs and prepaid dental plan providers in major port cities. Health Net PPO for Employees electing such coverage and paying the required monthly self-payment.</p> <p>The Plan provides direct reimbursement of HMO and Health Net PPO Plan (excluding Health Net non-PPO provider charges) copayments and out-of-pocket expenses incurred up to the usual, customary and reasonable charges for medical and dental coverage not covered by one of the Plan's providers. Reimbursements are only provided for services that would have been covered in full under the USPHS Replacement Program.</p>
DEATH BENEFIT	\$25,000; available to eligible beneficiaries of Employees who have one day of seagoing employment with a Participating Employer in the 365 days immediately preceding the date of death and provided that Employer contributions were made to the plan.
BURIAL BENEFIT	\$500; available to claimants of Employees who do not meet the eligibility requirements for the Death benefit, provided the Employee had at least 1,000 days of Covered Employment and who at his death had shipping rights under the collective bargaining agreement.
HOSPITAL COMFORT BENEFIT	\$4 per day of inpatient hospital confinement for reimbursement of personal expenses; with PHS Replacement Program eligibility.
HOSPITAL ALLOWANCE	\$12 per day of inpatient hospital confinement to a maximum of 20 days; with PHS Replacement Program eligibility.
TEMPORARY DISABILITY	\$75 per week for up to 52 weeks. The benefit coordinates with any State Disability Benefits available.
VISION CARE BENEFIT	\$200 maximum for vision care expenses every 24 months.
HEARING AID BENEFIT	\$400 maximum per ear, payable once every four years.
EMPLOYEE ASSISTANCE PROGRAM	Confidential assistance for drug, alcohol and other mental health issues.
ALCOHOL TREATMENT/SUBSTANCE ABUSE REHABILITATION BENEFIT	Contract Provider only; reimbursed at 100%; limited to one treatment program per lifetime; second treatment program may be authorized by Trustees.

ACTIVE EMPLOYEES' DEPENDENT MEDICAL BENEFITS

Medical benefits provided through contracts with HMOs providers in major port cities. Health Net PPO for Employees and their Dependents electing such coverage and paying the required monthly self-payment.

ACTIVE EMPLOYEES' DEPENDENT DENTAL BENEFITS

(you may elect only one coverage option)

DIRECT PAYMENT PLAN

100% of scheduled amounts, no annual maximum.

PREPAID DENTAL PLAN

Dental benefits provided through contracts with prepaid dental plan providers in major port cities.

PENSIONER BENEFITS

BURIAL BENEFIT

If a Pensioner had been receiving pension payments from the SIU Pacific District Pension Plan prior to his/her death, a burial allowance not to exceed the maximum scheduled benefit, is payable to the person who provides for the burial. The burial allowance will be prorated according to the Pensioner's qualifying pension contributions subject to a \$1,000 maximum.

HOSPITAL COMFORT BENEFIT

\$4 per day with proof of hospitalization including admission and discharge dates.

PHS REPLACEMENT PROGRAM

For pensioners who are determined to be permanently unfit for duty by a Plan physician at retirement and who are receiving a Disability Pension from the SIU PD Pension Plan. Benefits cease when the pensioner becomes eligible for Medicare.

ANNUAL MEDICAL AND HOSPITAL BENEFIT

Eligible Pensioners and their spouses can receive an annual benefit of up to \$2,000 per family (those who receive less than a full pension get a prorated portion of the \$2,000). The benefit can be used to pay claims for medical, drug, dental, or vision services, or be used to reimburse for supplemental medical coverage purchased by the covered individuals, including paying Medicare Parts B and D premiums.

SPECIAL MEDICAL PENSIONERS BENEFIT

Effective August 1, 2015, eligible Pensioners and their dependents can receive an annual benefit of up to \$5,000 per family (those who receive less than a full pension get a prorated portion of the \$5,000). It can be used to pay claims for medical, drug, dental, or vision services, or be used to reimburse for supplemental medical coverage purchased by the covered individuals, including paying Medicare Parts B and D premiums. Benefit payments are subject to the following annual limits:

Eligible Premiums	\$ 3,000
Prescription Drug Expenses	1,000
Other	1,000

WIDOW'S BENEFIT

Pays each eligible widow a monthly benefit equal to the SIU Pacific District Pension Plan pensioner's benefit amount that the Pensioner would have received; for 12 months or, if sooner, until death.

ELIGIBILITY

ELIGIBILITY FOR EMPLOYEES AND ELIGIBLE DEPENDENTS

If you have any questions regarding eligibility, contact the Plan Office. Benefits for which you are eligible are based on your participating employer's contribution to the Plan.

Initial Qualifying Period:

The required number of days of Covered Employment, for which a contribution was made by the Employer during the Qualifying Period, will be 120 days of covered employment in a 365 day consecutive period to earn initial eligibility. Eligibility for Active Employee Benefits are classified into three groups; *Group 1, Group 2, and Group 3. **Active Employees' Dependent Benefits are provided if the Employee earns eligibility under Group 1 or Group 2.***

Eligibility will begin on the first day of the calendar month following the date when the required number of days of covered employment are accumulated. Covered employment includes employment as an Active Seaman of an Employer who contributes to the Plan's PHS Replacement Program.

Enrollment Form: No coverage is provided to an eligible Employee or Dependent unless and until a current enrollment card provided by the SUP Welfare Plan has been filed by the Employee. The Plan Office from time to time may require a new enrollment form if deemed necessary for the proper administration of benefit payments.

*See page 50 for the definition of eligible Dependents. **If you earned eligibility under Groups 1 or 2 and you are adding dependents, make sure to mail copies of marriage certificate for spouse and birth certificates for children. Failure to submit this documentation will delay your enrollment process.***

ELIGIBILITY OF NEWLY ACQUIRED DEPENDENTS

Newly acquired Dependents are eligible for coverage for the benefit year beginning on the date the Dependent is acquired. New Dependents must be enrolled within 30 days of being acquired (or as soon as reasonably possible) to avoid any lapse in coverage. If you enroll within the required time limits, coverage is effective retroactive to the date the Dependent is acquired.

If you do not enroll within the required time limits, coverage will be effective the first day of the month following the date you file the proper enrollment form with the Plan Office during the open enrollment period. Note: Notwithstanding the foregoing, Members already enrolled in a plan can change if they are in the current plan for 12 months.

Notice of Special Enrollment Rights: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if, in the future, you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage) or your gain or lose eligibility for Medicaid or CHIP (Children's Health Insurance Program). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage) (or 60 days following the loss of eligibility for Medicaid or CHIP coverage or the gaining of eligibility for premium assistance for Plan coverage under a Medicaid or CHIP program). Trust coverage will be effective on the first day of the month following the month in which the timely enrollment paperwork is received by the Administrative Office.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Coverage following a birth, adoption or placement for adoption will be effective of the date of the birth, adoption or

placement for adoption, while enrollment following marriage, will be effective on the first day of the month following the month in which the timely enrollment paperwork is received. To request special enrollment or obtain more information, contact the Plan Office.

GROUP 1

Participants who are employed in the following work categories will have mandays credited toward Group 1 eligibility:

- Maritime Security Fleet vessels operated by APL Marine Services, Ltd.
- Matson Navigation Company commercial vessels (except the IBT *Moku Pahu*)
- APL Marine Services, Ltd. or Matson Maintenance Agreements – Regular Shore Gang only; Extra Maintenance personnel are in Group 3

For Initial Group 1 Eligibility:

An employee will be required to work 120 qualifying mandays in a consecutive 12-month period to be entitled to Group 1 eligibility. 12 months of benefit coverage will be provided starting with the 1st day of the month following completion of the 120th qualifying manday. ***Qualifying mandays will include only mandays worked from Group 1 employment. Neither Group 2 nor Group 3 mandays can be used to establish or continue Group 1 eligibility.*** However, Group 2 mandays can be used to establish and continue Group 2 or 3 eligibility as explained under the Group 2 Eligibility rules below. Group 3 mandays can be used to establish and continue Group 3 eligibility as explained under the Group 3 Eligibility rules below.

Continuing Group 1 Eligibility:

After establishing initial eligibility, an employee will extend the initial 12-month benefit period by working a minimum of 60 qualifying mandays within that 12-month benefit period. Upon completion of the 60th qualifying manday, coverage will be rolled forward to provide 12 months of continuing coverage measured from the first day of the month following completion of the 60th qualifying manday. Each new period of 60 qualifying mandays will roll forward an employee's eligibility for up to 12 months, provided those mandays are all completed during the employee's most recent 12-month benefit period under Group 1. ***Qualifying mandays will include only mandays worked from Group 1 employment. Group 2 and Group 3 mandays cannot be used to continue Group 1 eligibility.*** Once a manday has been used to establish initial or continuing eligibility, it cannot be reused to establish or further extend an employee's eligibility.

Reestablishing Group 1 Eligibility:

To reestablish eligibility that has lapsed due to insufficient qualifying mandays, 120 qualifying mandays must be worked in a consecutive 12-month period beginning after Group 1 eligibility lapsed. ***Qualifying mandays will include only mandays worked from Group 1 employment. Group 2 and Group 3 mandays cannot be used to reestablish Group 1 eligibility.***

GROUP 2

Participants who are employed in the following work categories/Employers will have mandays credited toward Group 2 eligibility:

- Military vessels (LMSRs, RRF, etc.) operated by APL Marine Services, Ltd., Patriot or Matson Navigation Company
- Matson Navigation Company IBT *Moku Pahu*
- Employees of Foss Maritime

- Employees of SF Bar Pilots

For Initial Group 2 Eligibility:

An employee will be required to work 120 qualifying mandays in a consecutive 12-month period to be entitled to Group 2 eligibility. 6 months of coverage will be provided starting with the 1st day of the month following completion of the 120th qualifying manday. ***Qualifying mandays will include only mandays worked from both Group 2 and Group 1 employment. Group 3 mandays cannot be used to establish or continue Group 2 eligibility, but can be used to establish or continue Group 3 eligibility as explained under Group 3 Eligibility below.***

Continuing Group 2 Eligibility:

After establishing initial eligibility, an employee will extend the initial 6-month benefit period by working a minimum of 60 qualifying mandays within that 6-month benefit period. Upon completion of the 60th qualifying manday, coverage will be rolled forward to provide 6 months of continuing coverage measured from the first day of the month following completion of the 60th qualifying manday. Each new period of 60 qualifying mandays of employment will roll forward an employee's eligibility for up to 6 months, provided those mandays are all completed during the employee's most recent 6-month benefit period under Group 2. ***Qualifying mandays will include only mandays worked from both Group 2 and Group 1 employment. Group 3 mandays cannot be used to continue Group 2 eligibility, but may qualify for Group 3 eligibility.*** Once a manday has been used to establish initial or continuing eligibility, it cannot be reused to establish or further extend an employee's eligibility.

Reestablishing Group 2 Eligibility:

To reestablish eligibility that has lapsed due to insufficient qualifying mandays, 120 qualifying mandays must be worked in a consecutive 12-month period beginning after Group 2 eligibility lapsed. ***Qualifying mandays will include only mandays worked from both Group 2 and Group 1 employment. Group 3 mandays cannot be used to reestablish Group 2 eligibility.***

GROUP 3

Participants who are employed in the following work categories will have mandays credited toward Group 3 eligibility:

- Employees working under the APL Marine Services, Ltd. or Matson ***Extra*** Maintenance Agreements – Extra Maintenance Personnel (casual standbys)

Participants who become eligible under the following Group 3 eligibility rules qualify for PHS Replacement Program benefits under the Plan for themselves only; there is no dependent coverage for these participants.

For Initial Group 3 Eligibility:

An employee will be required to work 120 qualifying mandays in a consecutive 12-month period to be entitled to Group 3 eligibility. ***Qualifying mandays will include mandays worked from Group 3, Group 2 and Group 1 employment.*** 6 months of coverage will be provided starting with the 1st day of the month following completion of the 120th qualifying manday.

Continuing Group 3 Eligibility:

After establishing initial eligibility, an employee will extend the initial 6-month benefit period by working a minimum of 60 qualifying mandays within that 6-month benefit period. Upon completion of the 60th qualifying manday, coverage will be rolled forward to provide 6 months of continuing coverage measured

from the first day of the month following completion of the 60th qualifying manday. Each new period of 60 qualifying mandays will roll forward an employee's eligibility for up to 6 months. **Qualifying mandays will include mandays worked from Group 3, Group 2 and Group 1 employment.** Once a manday has been used to establish initial or continuing eligibility, it cannot be reused to establish or further extend an employee's eligibility.

Reestablishing Group 3 Eligibility:

To reestablish eligibility that has lapsed due to insufficient qualifying mandays, 120 qualifying mandays must be worked in a consecutive 12-month period beginning after Group 3 eligibility lapsed. **Qualifying mandays will include mandays worked from Group 3, Group 2 and Group 1 employment.**

It is important to note that the Plan will be tracking an employee's eligibility for benefit coverage separately based on work in each Group category. For example, if an employee loses Group 1 eligibility, the Plan will look at the mandays credited towards the other two eligibility Groups to determine if the Employee still has either Group 2 or Group 3 eligibility. Once an employee's eligibility under any Group lapses, that employee can only reestablish eligibility under that Group by once again satisfying the initial eligibility rules of that Group based on qualifying mandays since eligibility lapsed.

SPECIAL EXTENSIONS OF ELIGIBILITY FOR DISABILITY

The eligibility period of an Employee who becomes disabled will be extended as follows:

Not Fit for Duty Eligibility Extension

Definition:

Not-Fit-For-Duty means that an eligible Employee, by reason of injury or illness, is unable to engage in employment in the maritime industry. To be considered Not-Fit-For-Duty, the eligible Employee must present to the Plan valid documentation from a certified physician stating the cause, date the employee first became Not-Fit-For-Duty and the expected duration of the Not-Fit-For-Duty status. The final determination of the validity of the Not-Fit-For-Duty status for purposes of eligibility under the SUP Welfare Plan shall rest with the Plan.

Eligibility Extension:

If an eligible Employee remains in the industry (maintains seniority shipping rights) hoping to recover his health and is not declared Permanently-Not-Fit-For-Duty, he and his Dependents will continue to be eligible for a maximum of 18 months under this provision from the date he became Not-Fit-For-Duty, or until he becomes Fit-For-Duty, whichever comes first.

If an eligible Employee becomes Fit-for-Duty within 18 months after he became Not-Fit-For-Duty and while still eligible for Active Employee benefits, he and his Dependents will continue to be eligible for a period of **three calendar months** following the month in which he becomes Fit-For-Duty or for the balance of the Benefit Anniversary Period for which he last earned eligibility based on mandays, whichever is greater.

(The three calendar month period would allow a participant to work the required minimum 60 mandays to continue eligibility for another benefit term).

Exception: If an eligible Foss Employee becomes Fit-for-Duty within 18 months after he became Not-Fit-For-Duty and while still eligible for Active Employee benefits, he and his Dependents will continue to be eligible for a period of **three calendar months** following the month in which he becomes Fit-For-Duty or for the balance of the Benefit Anniversary Period for which he last earned eligibility based on mandays, whichever is greater. **A Foss Employee returning to work upon becoming Fit-for-Duty while receiving Trust benefits on a Not Fit for Duty Extension will be credited with 30 mandays for each**

month in which he works a minimum of 14 mandays. After establishing benefit eligibility for another term, standard Trust eligibility rules will apply and mandays will be credited on a 1:1 ratio.

Permanently-Not-Fit-For-Duty Eligibility Extension

Definition:

Permanently Not-Fit-For-Duty means that in the written opinion of his/her attending physician that an eligible Employee will be unable to recover his/her health sufficiently to return to Covered Employment within the maritime industry. The final determination of the validity of the Permanently Not-Fit-For-Duty status for purposes of eligibility under the SUP Welfare Plan shall rest with the Plan.

Eligibility Extension:

If an eligible Employee does not retire permanently from the industry but is declared Permanently-Not-Fit-For-Duty, he and his Dependents will continue to be eligible for a maximum of 12 months under this provision from the date that his Attending Physician certifies that he his Permanently-Not-Fit-For-Duty.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Within a reasonable period of time after the plan receives a medical child support order, the Plan Office will notify the Participant and each alternate recipient of the determination of whether such order is qualified under ERISA Section 609 by applying approved procedures.

TERMINATION OF ELIGIBILITY AND COVERAGE

Eligibility for benefits will terminate on the earliest of the following dates:

1. The end of the six or twelve-month eligibility period if not extended as set forth under the section entitled "Continuing Eligibility";
2. The Employee becomes eligible as a Pensioner;
3. The Employee receiving benefits under the Extended Benefit Period due to disability or continuing medical treatment becomes covered as an Employee under another group health plan, whichever occurs first; or
4. The Employee received benefits from the SUP Money Purchase Pension Plan or the 401(k) Plan with the exception of a required minimum distribution.

TERMINATION OF DEPENDENTS' COVERAGE

A Dependent's coverage for benefits will terminate on the earliest of the following dates:

1. The date that the Employee's coverage terminates;
2. First day of the calendar month that the Employee retires on a SIU Pacific District Pension;
3. The Employee receiving benefits under the Extended Benefit Period due to disability or continuing medical treatment becomes covered as an Employee under another group health plan, whichever occurs first;
4. First day of the calendar month immediately following the date a Dependent is no longer an eligible Dependent;

5. First day of the calendar month immediately following the date the Employee leaves the industry; or the Employee receives benefits from the SUP Money Purchase Pension Plan or 401(k) Plan with the exception of a required minimum distribution; or
6. First day of the fourth calendar month immediately following the date of the Employee's death.

COBRA CONTINUATION OF COVERAGE SELF-PAYMENT PROVISIONS

(Exclusive of Death and Burial Benefits, Temporary Disability Benefits, and Rehabilitation Benefits)

Important Note: There may be other coverage options for you and your family besides the COBRA coverage described in this section.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You are able to buy coverage through the Health Insurance Marketplace if you are a US Citizen or legal resident. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

The following is an explanation of your rights under COBRA. You and your dependents should read this section carefully. COBRA is a federal law that requires group health plans to allow employees and their dependents to continue group health coverage at their own expense for a period of time after group health plan coverage ends.

If you or your Dependent loses coverage under the Plan as a result of a Qualifying Event, coverage may be continued for a limited period under COBRA Continuation Coverage by making monthly payments to the Plan.

Qualifying Events are:

Employees

If an Employee loses coverage as a result of:

- Termination of your employment for reasons other than your gross misconduct (including retirement); or
- Reduction in the hours of your employment (in other words, when your man days worked for a contributing employer are not enough to continue eligibility). If you are on an approved leave of absence subject to the Family and Medical Leave Act (FMLA), only failure to return to work at the end of the approved leave constitutes a "qualifying event." If you are on an approved military leave of absence subject to the Uniformed Services Employment and Reemployment Rights Act

(USERRA) for less than 31 days and you fail to return to work at the end of the leave, your "qualifying event" occurs on the first day after you fail to return to work at the end of your leave.

Employees' Dependent Spouse or Dependent Children

If a dependent spouse or dependent children covered under the Plan, loses coverage as a result of:

1. The Employee's death;
2. The Employee's Qualifying Event;
3. The Employee's divorce or legal separation;
4. The loss of Eligible Dependent status; or
5. The Employee's entitlement to Medicare.

Please contact the Plan Office if you have a COBRA Qualifying Event.

An Employee, Spouse or Dependent Child are considered Qualified Beneficiaries and can individually elect to continue coverage under COBRA in accordance with this section. Please read this entire section very carefully so that all requirements and restrictions are completely understood.

If you pay a family rate, your COBRA coverage under this Plan includes coverage for any child born or adopted by you after your COBRA effective date. The child will become covered on the date of birth or placement for adoption and will be covered as a Qualified Beneficiary as long as you remain eligible for COBRA coverage. Any Qualified Beneficiary may also add a new spouse and other dependents to their coverage; however, only natural or adopted children of the former employee have the rights of a Qualified Beneficiary, such as the right to stay on COBRA coverage longer if a second Qualifying Event occurs.

Duration of Coverage

The maximum period for which a Qualified Beneficiary may continue COBRA Continuation Coverage is as follows:

Employee:

Eighteen consecutive months from the date of the Qualifying Event.

Spouses and Dependent Children:

1. If coverage ceases as a result of the Employee's Qualifying Event, coverage may be continued under COBRA Continuation Coverage for a maximum period of 18 consecutive months from the date of the Qualifying Event.
2. If coverage ceases as a result of the Employee's death, divorce, legal separation or entitlement to Medicare Benefits, COBRA Continuation Coverage may be continued for a maximum of 36 consecutive months from the date of the Qualifying Event.
3. If coverage for a Dependent Child ceases as a result of that child's no longer qualifying as a "Dependent" under the terms of the Plan, the Dependent Child may continue COBRA Continuation Coverage for a maximum of 36 consecutive months from the date of the Qualifying Event.

Although a Spouse or Dependent Child who are considered Qualified Beneficiaries may suffer more than one Qualifying Event, the maximum duration of COBRA Continuation Coverage is 36 consecutive months from the date of the first Qualifying Event.

Coverage Options

Qualified Beneficiaries may elect:

COBRA Core-Only: This includes Medical and Prescription benefits. Dental coverage can be added for additional cost.

Note: You may only elect and be covered by the same plan under which you were covered the day prior to the Qualifying Event. For example, if you were covered by the Direct Payment Plan, you may not elect an HMO Health Plan under COBRA Continuation Coverage.

The COBRA rates are adjusted once each year and current rates may be obtained from the Plan Office.

Notice and Election Procedures

In order to elect COBRA Continuation Coverage, a Qualified Beneficiary must notify the Plan Office of certain Qualifying Events, which are:

1. An Employee's divorce or legal separation; or
2. An Employee's entitlement to Medicare; or
3. When a Dependent Child no longer qualifies as a "Dependent" as defined on page 52.

In the case of any other Qualifying Event, the Employer must notify the Plan Office within 30 days of the date coverage would otherwise be lost.

Note: Notice of a Qualifying Event must be made in writing on a form that may be obtained by calling the Plan Office. If a Qualified Beneficiary fails to file this form with the Plan Office within 60 days of the Qualifying Event or 60 days from the date coverage ends (whichever is later), the right to continue coverage will be terminated.

Following receipt of this notification, the Plan Office will send a letter within 14 days to the Qualified Beneficiaries explaining their options to continue coverage. This letter will be addressed to the Employee and Dependents at the address of record maintained by the Plan Office.

It is the responsibility of all Participants to keep the Plan Office informed in writing of any changes in mailing address.

Qualified Beneficiaries have 60 days from the later of (a) the date they received the COBRA continuation letter, or (b) the date coverage terminates, to make a written election to continue coverage. The first monthly payment is due when the election form is returned to the Plan Office, and will not be accepted after 45 days from that date. Subsequent payments are due on the first day of each month, and will not be accepted more than 30 days late.

If a timely election to continue coverage is made, continued coverage will commence on the first day of the month following the date of the Qualifying Event. However, Qualified Beneficiaries will not be required to make payments for months during which coverage is otherwise provided under the Plan.

Termination of COBRA Continuation Coverage

Cobra Continuation Coverage will automatically terminate upon the earliest of the following dates:

1. The Qualified Beneficiary becomes covered under any other group health plan (including a retiree health plan) without limitation of a pre-existing condition that the Qualified Beneficiary has; or
2. The month for which a timely payment is not received by the Plan Office; or

3. The Qualified Beneficiary becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or
4. The last day of the maximum coverage period applicable to the Qualified Beneficiary; or
5. The Employee's Employer no longer provides any group health coverage to any Employee.
6. With respect to COBRA coverage during the 11-month extension due to a Qualified Beneficiary's disability, if there is a final determination under Title II or XVI of the Social Security Act that the Qualifying Beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).

Exceptions to Termination of COBRA Coverage

1. Qualified Beneficiaries who lose coverage due to insufficient days of employment or termination of employment, and are determined under Title II or XVI of the Social Security Act to be disabled at any time before or during the first 60 days of COBRA Continuation coverage, may extend continuation coverage for themselves and eligible family members from 18 months to 29 months.

There will be an increased rate, which will be 150% of the plan's cost for the 19th through 29th month. Further, the Qualified Beneficiary must notify the Plan Office of such determination of disability: (a) prior to the end of the 18 months and within 60 days after the date of determination, and (b) within 30 days of the date of any final determination under Title II or XVI of the Social Security Act that the individual is no longer disabled.

2. If a covered employee prior to his Qualifying Event becomes entitled to Medicare coverage, the maximum period of coverage for his Dependents for such event or any subsequent Qualifying Event is 36 months.
3. Your COBRA coverage will end if you become covered under another plan obtained after COBRA coverage started, unless the plan has an exclusion or limitation for pre-existing condition(s) which affects you or one of your dependents. If your new plan begins to allow coverage for the preexisting condition affecting you or your dependent, COBRA coverage under this Plan will end.

EMPLOYEE BENEFITS

Benefits Provided to Eligible Active Employees Only

PHS REPLACEMENT PROGRAM

Prior to 1981, seamen were eligible for medical and dental treatment at U.S. Public Health Hospitals.

It is the intent of this program to provide health services reasonably comparable to the services provided by the U.S. Public Health Service. The determination that any medical or dental service or supply to be provided as a benefit under this Program is "reasonably comparable" rests solely with the Trustees.

The PHS Replacement Program is provided only to Active Employees or Pensioners who have met the eligibility requirements listed on pages 16 - 20 and 38. Employees eligible for the PHS Replacement Program are not eligible for benefits under any other program of the SUP Welfare Plan for expenses incurred for medical services and supplies, dental services, or prescription drugs, except vision care benefits which will continue to be provided to active Employees subject to the eligibility requirements and limitations of the vision care program. Coverage under the PHS Replacement Program is limited solely to the eligible Employee or eligible Pensioner.

Providers

An eligible Employee may choose a medical plan and a dental plan of the Program, provided the Employee meets the requirements set forth by the provider. Once enrolled in a medical and dental, the Employee cannot change to another prepaid or insured plan until the month before the annual renewal date for the provider or until a period of at least 12 consecutive months has elapsed, unless the Employee moves out of the service area or provides evidence of dissatisfaction with a provider. Such change must be requested in writing and directed to the Plan Office.

The Plan provides benefits by payment of premiums for the coverage provided by Kaiser Foundation Health Plan of Northern California, Kaiser Foundation Health Plan of Southern California, Kaiser Foundation Health Plan of Oregon, Kaiser Foundation Health Plan—Hawaii Region, Group Health Cooperative of Puget Sound, Blue Cross/Blue Shield of Louisiana, Health Net of California, Dental Health Services, Delta Care, United Health Care Dental, AIG Benefit Solutions and Dina Dental Plan—New Orleans. A list of addresses for each of the providers starts on Page 4.

Benefits

Benefits provided pursuant to an insurance or HMO contract are subject to the contract between the provider and the SUP Welfare Plan. Please refer to the applicable prepaid brochure or Evidence of Coverage/Certificate for a list of covered services.

Limitations and Exclusions

No benefit is payable by the Plan for services provided and paid for by a prepayment or insured medical plan or dental plan in which an Employee is enrolled or is eligible to be enrolled. Additional limitations and exclusions for benefits are described in the applicable Evidence of Coverage/Certificate of Coverage or insurance contract.

HEARING AID BENEFITS

A benefit allowance of up to \$400 maximum is payable for a hearing aid subject to the following:

1. The need for a hearing aid to continue employment or to participate in normal activities is certified by a licensed Physician;
2. The benefit allowance will be payable once in four years except if certified that a hearing aid is required in each ear, a benefit allowance of up to an additional \$400 is payable for expense incurred for the additional appliance but no more frequently than once every four years.

No benefit will be payable for expense incurred for a hearing examination or prescription for a hearing aid if the Employee is enrolled or is entitled to be enrolled in a prepayment or insured medical plan.

No benefit will be payable for hearing aid batteries or repairs.

VISION CARE BENEFITS

The Plan will pay for the following covered vision benefits up to a maximum of \$200 every 24 months:

1. Complete eye examination once by an optometrist (O.D.) or an ophthalmologist (M.D.);
2. Lenses including sunglasses when required for safety or navigational purposes; and
3. Frames and/or
4. Contact lenses

No payment or allowance will be made for:

1. More than one eye examination or pair of glasses in a 24-month period;
2. Tint or photogrey lenses, unless required for safety or navigational purposes.

TEMPORARY DISABILITY BENEFIT

The Plan will pay an eligible Employee who becomes unfit to work because of an accident or illness, for any one continuous period of disability, an amount determined by multiplying the weekly benefit of \$75 times the number of weeks of disability, not to exceed 52 weeks. This benefit is coordinated with state disability programs. If you reside in a state with Disability Insurance benefits, the Plan will pay up to \$75 per week less any amount payable by the state. If the state disability benefit is greater than \$75 then you will not be eligible for benefit payments through the Plan.

INPATIENT HOSPITAL BENEFITS

Hospital Daily Allowance Benefit

The maximum benefit payable by the Plan for all Hospital confinements during any one continuous period of disability is \$12 per day up to a maximum of 20 days.

In-Hospital Comfort Benefit

The Plan will pay an eligible Employee confined in a Hospital located in the United States \$4 per day of Hospital confinement for personal expenses.

BENEFITS PAYABLE BY DIRECT REIMBURSEMENT

For reasonably comparable health service expenses in areas with Contracted Prepaid Providers (reasonably comparable to health services formerly provided by the U.S. Public Health Service):

1. The Program will pay benefits up to the maximum or Usual, Customary and Reasonable charges for such services or supplies that are not covered by the prepaid plan, subject to the following:
 - a. The Employee is enrolled in a prepaid or insured medical plan or prepaid or insured dental plan;
 - b. The prepayment or insured plan Physician or Dentist has prescribed in writing that the health service is essential for necessary care and treatment of the Employee as a result of non-occupational bodily injury or of an illness;
 - c. The health service is not otherwise limited or excluded.

PRESCRIPTION DRUGS

Benefits will be payable for drugs and medications according to the terms and conditions of the prepayment or insured plans if prescribed by a licensed Physician or Dentist.

ALCOHOL/SUBSTANCE ABUSE REHABILITATION BENEFITS

(Administered by Human Behavior Associates, Inc. (HBA))

Upon the recommendation of a contracted Plan Physician of this Program or a Physician designated by the Trustees and with advance approval by the Plan Office, the Program will provide alcohol and/or drug abuse rehabilitation services for eligible Employees at a designated treatment center. Contact the Plan Office for more information.

Detoxification is not covered under this benefit but is provided under the prepayment or insured medical plan.

No benefit is payable without preauthorization obtained from the Plan Office prior to admission to a facility selected by the Plan Office.

The facility to be authorized for rehabilitation services will be determined by the Plan Office solely on the basis of the level of medical care required during the period of rehabilitation.

Benefits are limited to one rehabilitation admission per Employee not to exceed a period of 28 days of rehabilitation treatment during the Employee's lifetime.

EMPLOYEE ASSISTANCE PROGRAM

(Administered by Human Behavior Associates, Inc. (HBA))

This program enables participants who encounter drug or alcohol abuse problems to call a twenty-four hour, seven day a week confidential toll free number for counseling and assistance. Information and an EAP calling card will be issued to the employee upon enrollment in medical coverage or upon request.

DEATH AND BURIAL BENEFITS

The Plan will pay a Death benefit of \$25,000 when there is a named beneficiary, subject to the following provisions:

Beneficiary

1. **Designated Beneficiary** - Benefits will be paid to the beneficiary designated on a properly executed Authorized Beneficiary Form by the Employee if such beneficiary survives the Employee. Such designated beneficiary will include only the eligible Employee's spouse, children, mother, father, stepmother, stepfather, stepchildren, sister, brother, half brother, half sister, niece, nephew, aunt, uncle, grandmother, grandfather, grandchildren, or a valid trust for the exclusive benefit for one or more of the foregoing.
2. **Change of Beneficiary** - The eligible Employee may designate a beneficiary or may change a previously designated beneficiary by filing with the Plan Office a properly executed Authorized Beneficiary Form. The requested beneficiary change will take effect on the date the request was signed.
3. **Multiple Beneficiaries** - If more than one beneficiary is designated and the eligible Employee has failed to specify their respective interest, the beneficiaries will share equally in any survivor's benefits.
4. **Minor Child Beneficiary** - In the event of the death of an eligible Employee who has designated a minor child as beneficiary, payment will be made to the person having the care, custody and obligation for support of the child or children upon receipt by the Plan Office of a "hold harmless" agreement in a form acceptable to the Trustees.
5. **Estate of Deceased Eligible Employee** - No benefit will be paid at any time under any circumstances to the estate of a deceased eligible Employee.

When there is No Designated Beneficiary

If no beneficiary has been designated by the eligible Employee, or if the designated beneficiary does not survive the eligible Employee, no death benefit will be paid. A burial benefit for actual cost, up to a maximum of \$500 will be paid.

No death benefit will be payable:

1. When a death benefit is payable by one or more of the SIU Pacific District Funds;
2. For the death of any Employee who, at the time of death, is receiving a pension from any related pension plan;
3. For the death resulting from a risk or peril for which benefits are payable under a policy provided for seamen by the United States Government or by a policy carried, or an insurance program maintained by an Employer in compliance with a Collective Bargaining Agreement with the Union. This provision will be deemed to include a policy or program providing benefits substantially the same as those commonly known as War Risk Policy Insurance Coverage;
4. For a claim filed more than two years after written notice from the Plan that a claim may be payable.

The amount of the death benefit paid will be reduced by the amount of any lump sum death benefits paid on behalf of such deceased eligible Employee by any (a) group, (b) group coverage arranged through any Employer, Trustees, Union or Employee Benefit Association, (c) any group coverage provided by a

school or educational institution, or (d) any group coverage under any governmental program or required or provided by any statute except any death benefits payable in accordance with an individual policy will not be used to reduce the death benefit.

Burial Benefit

Upon receipt by the Plan Office of proof of the death of an Employee, the Plan will reimburse a burial benefit up to a maximum of \$500 provided that the Employee had 1,000 days or more of covered employment.

REHABILITATION BENEFIT

Eligible Employees who have exhausted all of their regular benefits payable by the Plan Office and who are not recipients of Social Security benefits and who are Totally Disabled will be granted a monthly allowance of \$80 for a period of up to 12 months. The Plan Office may require such disabled Employee to submit to a medical examination to confirm that the Employee is Totally Disabled.

ACTIVE EMPLOYEES' DEPENDENT BENEFITS

(provided to Dependents of Active Employees who earn Eligibility under Group 1 and Group 2)

BENEFITS FOR DEPENDENTS OF ELIGIBLE EMPLOYEES WITH GROUP 1 OR GROUP 2 ELIGIBILITY

Selection of Medical and Dental Plans

Eligible Employees may elect to cover their Dependents under either the Direct Dental Payment Plans or the same Dental Plans that the Employee has selected. Dependents may only be covered under the same Medical Plan selected by the Employee.

Each Employee will be permitted to make a change in his choice of Medical Benefit Plan coverage. However, following enrollment in any Plan, the Employee and his/her Dependents cannot change to another Medical or Dental plan until the month before the annual renewal date for the provider or until a period of at least 12 consecutive months has elapsed, unless the Employee moves out of the service area or provides evidence of dissatisfaction with a provider. Such change must be requested in writing and directed to the Plan Office.

In any event, while enrolled in an insured Dental Benefits Plan, no Dependent will be eligible for any payment of benefits under the Direct Payment Plan.

The Plan provides benefits by payment of premiums for the coverage provided by Kaiser Foundation Health Plan of Northern California, Kaiser Foundation Health Plan of Southern California, Kaiser Foundation Health Plan of Oregon, Kaiser Foundation Health Plan—Hawaii Region, Group Health Cooperative of Puget Sound, Blue Cross/Blue Shield of Louisiana, Health Net of California, Dental Health Services, Delta Dental PMI, United Health Care Dental, AIG Benefit Solutions and Dina Dental Plan—New Orleans. A list of addresses for each of the providers starts on Page 4.

DENTAL BENEFITS - DIRECT PAYMENT PLAN

Covered Dental expenses incurred by an eligible Dependent will be payable by the Plan at 100% of the amount shown for each dental procedure in the Schedule of Dental Procedures and Allowances.

All dental bills submitted to the Plan Office by Dependents residing outside of the United States for payment under the Direct Payment Plan must be translated into English and converted into United States currency. Claims must include the date of service, description of charges, and name of patient.

Any expense or charge is deemed to be incurred on the date the service is rendered from which the expense or charge arises.

Benefits are payable for:

1. **Diagnostic** - Procedure to assist the dentist in evaluating the existing conditions to determine the required dental treatment;
2. **Preventive** - Prophylaxis (cleaning) once every six consecutive months, topical application of fluoride solutions, and space maintainer;
3. **Oral Surgery** - Procedures for extractions and other oral surgery including preoperative and postoperative care;
4. **General Anesthesia** - When administered for a covered oral surgery procedure performed by a dentist;
5. **Restorative** - Provides amalgam, synthetic porcelain, and plastic restoration for treatment of carious lesions. Gold restorations, crowns, and jackets will be provided when teeth cannot be restored with the above materials;
6. **Endodontic** - Procedure for pulpal therapy and root canal filling;
7. **Periodontic** - Procedures for treatment of the tissues supporting the teeth;
8. **Prosthodontic** - Procedures for construction of bridges, partial and complete dentures;
9. **Dental Accident** - Necessary diagnostic and dental treatment rendered within 180 days following the date of a non-occupational accident for conditions caused, directly and independently of all other causes, by external, violent, and accidental means.

Covered Dental Expenses

Covered Dental Expenses means only expenses incurred for necessary treatment received from a dentist for any procedure which is specified in the Dental Schedule. If the procedure is not listed in the schedule, the Plan Office will determine the applicable amount for such procedure of equal severity listed in the Schedule.

Dental Exclusions

You are not covered for:

1. Injuries sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit, or disease for which benefits are payable in accordance with the provisions of any Worker's Compensation or similar law;
2. Cosmetic or orthodontic treatment, other than charges for extractions in connection therewith and charges for space maintainers;

3. Charges with respect to congenital or developmental malformations;
4. Services which are provided by any Federal or State Government Agency, or are provided without cost by a Municipality, County, or other political subdivision, except as provided in Section 12532.5 of the California Government Code;
5. Services rendered by other than a licensed Dentist or Physician, except charges for dental prophylaxis performed by a licensed Dental Hygienist, under the supervision and direction of a Dentist.
6. Charges incurred that are for medical services in nature.

Dental Limitations

Diagnostic and Prosthodontic services are subject to the following limitations:

1. Complete mouth x-rays are provided only once in a consecutive three-year period, unless special need is shown. Supplementary bitewing x-rays are provided upon request, but not more than once every six consecutive months.
2. Crowns, jackets and gold restorations will be replaced only after five years have elapsed following such treatment under this Plan.
3. A prosthodontic appliance is a covered benefit once in a consecutive five-year period under this Plan, except when replacement is necessary for reasons of health; e.g., excessive tissue change, extensive loss of remaining teeth, or changes in supporting tissues. Payment for replacement of a prosthetic appliance will be made only if the appliance cannot be made satisfactory.

Optional Dental Treatment

In all cases in which the Dependent selects a more expensive plan of treatment than is customarily provided, the Plan will pay the allowance for the less expensive procedure as follows:

1. **Partial Dentures** - The Plan will provide a standard cast chrome or acrylic partial denture or will allow the cost of such procedure toward a more complicated or precision appliance that the patient or Dentist may choose to use;
2. **Complete Dentures** - If in the construction of a denture, the patient and dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Plan will allow an appropriate amount for the standard denture toward such treatment and the patient must bear the difference in cost;
3. **Occlusion** - The plan will allow the cost of restorations to replace missing teeth. Procedures, appliance, restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional, and the cost is the responsibility of the patient. Such procedures include, but are not limited to equilibration, periodontal splinting, restoration of tooth structure lost from attrition, and restoration and malalignment of the teeth;
4. **Implants** - If implants are utilized, this Plan will allow the cost of a standard complete or partial denture toward the cost of implants and appliances constructed in association with dentures. The Plan will not provide payment for surgical removal of implants.

Pre-Authorization for Dental Treatment

It is recommended that the Dentist submit a treatment plan to the Plan Office prior to rendition of service if charges will total \$500 or more.

The Plan Office will notify the Dentist submitting the treatment plan of approval or disapproval. No benefits will be paid for any dental services furnished in conjunction with a treatment plan which has been disapproved by the Plan Office. This need not change the plan of treatment, but it establishes a benefit allowance for services upon which Patient and Dentist agree, irrespective of the benefit the Plan will pay.

Such authorization for a treatment plan will remain in effect for a maximum of 60 days from the date of authorization or up to the date of termination of eligibility, whichever occurs first.

SCHEDULE OF DENTAL PROCEDURES AND ALLOWANCES

CODE	DESCRIPTION	AMOUNT
VISITS		
0120	Office visit; to include observation and/or treatment of injuries and observation of patient when no other services are provided (regular office hours)	\$12.96
9440	Professional visit; after hours; in addition to service provided	\$28.80
9310	Special consultation (by specialist only—when patient not treated by consultant)	\$23.04
1120	Prophylaxis—children to age 14	\$14.40
1110	Prophylaxis—treatment to include scaling of unattached tooth surfaces, and polishing—adult	\$20.16
1201	Topical application of fluoride including prophylaxis—to age 14	\$23.04
1202	Topical application of fluoride including prophylaxis—adult	\$23.04
9110	Emergency treatment—palliative, per visit	\$17.28
DIAGNOSTIC (<i>Film procedures include exam and diagnosis</i>)		
0220	Single film	\$5.76
0230	Additional, up to 12 films	\$2.88 each
0210	Entire denture series consisting of at least 14 films (including bite-wings, if necessary)	\$28.80
0240	Intra-oral, occlusal view, maxillary or mandibular, each	\$8.64
0250	Lateral jaw, lateral or P/A Head, one film	\$14.40
0260	Lateral jaw, lateral or P/A Head, two films	\$20.16
0272	Bite-wing films, two films	\$11.52
0274	Bite-wing films, four films	\$14.40
0330	Panographic-type film only	\$23.04
0340	Cephalometric film only	\$23.04
0341	Cephalometric film, each additional	\$11.52
0321	Temporomandibular articulation X-ray survey (includes all necessary films)	\$38.88
0350	Orthodontic x-ray survey (entire denture series and all other films, including cephalometric and photos)	\$53.28
7286	Biopsy of oral tissue, incisional	\$28.80
0450	Microscopic examination of biopsied material	\$25.92
ORAL SURGERY (<i>General Anesthesia—See Procedure #9220</i>)		
EXTRACTIONS (<i>Includes local anesthesia and routine post-operative visits.</i>)		
7110	Uncomplicated—single	\$18.72
7120	Each additional uncomplicated tooth (same date of service)	\$15.84
7210	Surgical removal of an erupted tooth	\$34.56
7250	Removal of residual root totally covered by bone	\$40.32

CODE	DESCRIPTION	AMOUNT
9930	Post-operative visit—complications (i.e. osteitis)	\$11.52
7220	Removal of impacted tooth (soft tissue)	\$34.56
7230	Removal of impacted tooth (partially bony)	\$51.84
7240	Removal of impacted tooth (completely bony)	\$74.88
ALVEOLAR AND GINGIVAL RECONSTRUCTION		
7320	Alveoplasty (edentulous), per quadrant	\$46.08
7310	Alveoplasty (in addition to removal of teeth), per quadrant	\$28.80
7340	Vestibuloplasty with ridge extension (secondary epithelialization)	\$69.12
7470	Removal of exostosis—maxilla or mandible	\$69.12
7971	Removal of mandibular tori, per quadrant	\$57.60
7970	Excision of hyper-plastic tissue, per arch	\$51.84
7850	Menisectomy of temporomandibular joint	\$576.00
7530	Incision and removal of foreign body from soft tissue	\$28.80
7960	Frenectomy	\$46.08
7910	Suture of soft tissue wound or injury	By Report
7280	Crown exposure with attachment placed for orthodontic traction	\$34.56
7899	Injection of temporomandibular joint	\$40.32
9212	Treatment trigeminal neuralgia by injection into second and third divisions	\$46.08
7281	Crown exposure to aid eruption	\$28.80
DRUGS		
9610	Drugs administered by dentist—injectable therapeutic	\$7.20
ANESTHESIA		
9220	Anesthesia, general, one-half hour (office administration)	\$28.80
9221	Anesthesia, general, each additional 15 minutes (office administration)	\$17.28
PERIODONTICS		
4910	Recall following active surgical periodontal treatment after four months (includes any prophylaxis, root planing, and curettage as necessary)	\$28.80
4930	Emergency treatment (periodontal abscess, acute periodontitis, etc.)	\$23.04
4220	Subgingival curettage and root planing per quadrant (not prophylaxis and scaling—see Procedure #050)	\$28.80
9951	Correction of occlusion —per quadrant (minor spot grinding, not equilibration)	\$28.80
4210	Gingivectomy per quadrant (including post-surgical visits)	\$92.16
4260	Gingivectomy, osseous or muco-gingival surgery per quadrant (includes post-surgical visits)	\$115.20
4211	Gingivectomy, treatment per tooth (fewer than six teeth)	\$23.04
ENDODONTICS		
3110	Direct pulp capping	\$11.52
3220	Therapeutic pulpotomy (in addition to restoration) per treatment	\$23.04
3120	Indirect pulp capping (recalcification) including temporary restoration	\$18.72

CODE	DESCRIPTION	AMOUNT
ROOT CANAL THERAPY		
3351	Culture canal	\$14.40
3310	Single canal	\$115.20
3320	Two canals	\$155.52
3330	Three canals	\$195.84
3340	Four canals	\$230.40
3420	Apical Surgery including filling of root canal and/or retrograde therapy—single operation	\$144.00
3410	Apicoectomy (separate procedure)	\$80.64
3920	Hemisection, root amputation	\$60.48
3351	Apexification, per visit	\$28.80
SPACE MAINTAINERS <i>(The following procedures include all adjustments within six months following installation.)</i>		
1525	Removable, plastic	\$74.88
1526	Additional clasps	\$11.52
0470	Diagnostic study models	\$17.28
1510	Fixed, unilateral band type	\$63.36
1511	Fixed, stainless steel crown type	\$74.88
1515	Fixed, lingual or palatal bar type	\$92.16
1530	Fixed or removable appliance to control thumb sucking	\$86.40
PROSTHETICS		
PONTICS		
6210	Cast (sanitary), metal	\$144.00
6220	Slotted facing (Steele's type)	\$132.48
6230	Slotted pontic (Tru-pontic type)	\$146.88
6235	Pin facing	\$167.04
6240	Porcelain with metal	\$201.60
6250	Plastic with metal	\$155.52
REMOVABLE UNILATERAL		
5281	One piece casting, chrome cobalt alloy clasp attachment (all types), per unit—including pontics	\$60.48
RECEMENTATION		
2910	Inlay (recementation)	\$17.28
2920	Crown (recementation)	\$17.28
6930	Bridge (recementation)	\$25.92
REPAIRS, CROWN & BRIDGE		
6600	Bridge repair—based on time and laboratory charges	By Report

CODE	DESCRIPTION	AMOUNT
DENTURES <i>(Procedures relating to dentures, partial dentures and relines include adjustments for six-month period following installation. Such procedures do not include specialized techniques involving precision dentures, personalization or characterizations.)</i>		
5110	Complete upper denture	\$345.60
5120	Complete lower denture	\$345.60
5211	Partial acrylic upper or lower, cast metal clasps—base	\$218.88
5213	Partial upper or lower with chrome cobalt alloy palatal or lingual bar and acrylic saddles—base	\$316.80
5310	Teeth and clasps—extra per unit (for 5211, 5213) 10 clasps	\$17.28
6940	Simple stress breakers—extra	\$40.32
5820	Anterior stayplate (temporary)—base	\$86.40
5822	Teeth and clasps extra per unit (for 5820)	\$14.40
5410	Denture adjustment	\$11.52
5730	Office reline—(cold cure)—acrylic	\$48.96
5750	Denture reline (laboratory)	\$86.40
5850	Special tissue conditioning, per denture - maximum two per denture	\$28.80
5700	Denture duplication (jump case), per denture	\$138.24
REPAIRS, FULL DENTURES		
5510	Broken full denture (no teeth involved)	\$28.80
5520	Replace missing or broken teeth, each	\$17.28
REPAIRS, PARTIAL DENTURES <i>(Adding teeth to partial denture to replace extracted natural teeth)</i>		
5640	First tooth, or clasp	\$40.32
5660	First tooth with clasp	\$57.60
5690	Each additional tooth, or clasp	\$23.04
5691	Partial denture repairs, other than 5640, 5660 or 5690 (based on time and laboratory charges)	By Report
RESTORATIVE DENTISTRY		
2110	Amalgam restoration—primary teeth, one surface	\$14.40
2120	Amalgam restoration—primary teeth, two surfaces	\$20.16
2130	Amalgam restoration—primary teeth, three or more surfaces	\$25.92
2140	Amalgam restoration—permanent teeth, one surface	\$17.28
2150	Amalgam restoration—permanent teeth, two surfaces	\$24.48
2160	Amalgam restoration—permanent teeth, three surfaces	\$31.68
2161	Amalgam restoration—permanent teeth, four or more surfaces	\$40.32
2510	Gold restoration, one surface	\$86.40
2520	Gold restoration, two surfaces	\$115.20
2530	Gold restoration, three or more surfaces	\$138.24
2540	Onlay, in addition to inlay per tooth—extra	\$23.04
2210	Silicate cement restoration	\$18.72
2310	Plastic or composite restoration	\$23.04

CODE	DESCRIPTION	AMOUNT
2335	Plastic or composite restoration, proximal surface involving incisal angle	\$34.56
2334	Pin retention, per tooth, additional (when necessary and final restoration is amalgam, plastic or composite)	\$11.52
CROWNS		
2710	Crown, plastic (permanent, processed)	\$115.20
2720	Plastic with metal	\$161.28
2740	Porcelain	\$161.28
2750	Porcelain with metal	\$207.36
2790	Full cast, metal	\$172.80
2810	3/4 metal	\$161.28
2950	Crown build-up. Procedure is included under crowns (see above) except in the exceptional instance where extensive build-up is needed (by written report and substantiating radiographic support). Amalgam or plastic build-up, including pins	\$34.56
2930	Stainless steel (primary)	\$40.32
2931	Stainless steel (permanent)	\$46.08
2954	Preformed dowel post (endodontically treated tooth), commercial	\$40.32
2952	Cast post with core or coping (endodontically treated tooth), office or laboratory castings	\$69.12
CYSTS, NEOPLASMS, MISCELLANEOUS		
7510	Intra-oral incision and drainage of abscess (soft tissue)	\$23.04
7520	Extra-oral incision and drainage of abscess	\$28.80
7971	Excision pericoronar gingiva	\$23.04
7980	Sialolithotomy: removal of salivary calculus, intra-orally	\$57.60
7981	Excision of salivary gland	\$230.40
7983	Closure of salivary fistula	\$86.40
7982	Dilation of salivary duct	\$28.80
7430	Resection of benign tumor, to 1.25 cm	\$46.08
7431	Resection of benign tumor, larger than 1.25 cm	\$57.60
7440	Resection of a malignant tumor	By Report
7270	Reimplantation and/or stabilization of accidentally evulsed or displaced teeth and/or alveolus	\$57.60
7272	Transplant of tooth or tooth bud	\$115.20
7540	Removal of foreign body from bone (independent procedure)	\$51.84
7440	Radical resection of bone for tumor with bone graft	By Report
7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$115.20
7260	Closure of oral fistula of maxillary sinus	\$74.88
7450	Excision of cyst, to 1.25 cm	\$46.08
7451	Excision of cyst, larger than 1.25 cm	\$86.40
7550	Sequestrectomy	\$40.32

PENSIONER BENEFITS

ELIGIBILITY FOR PENSIONER BENEFITS

Pensioners' benefits are based upon pension credits accrued with employers who paid contributions on their behalf to the SUP Welfare Plan. Pensioners receiving less than a full pension benefit will receive a prorated amount. If you have any questions concerning what proration may be applicable to you, please contact the Plan Office. Eligibility for the Basic Benefits and the Special Pensioners Benefit is based on age, service and eligibility in the SIU Pacific District Pension Plan.

ANNUAL MEDICAL AND HOSPITAL BENEFIT

- a. **Normal/Early Retirement:** Participants are eligible for pensioner benefits if the following conditions are met:
 - i. The pensioner is receiving pension benefits (other than a deferred vested benefit) under the SIU Pacific District Pension Plan; and
 - ii. The pensioner has 20 or more years of qualifying time from the SIU Pacific District Pension Plan and attained age 55 at the time of retirement; or
 - iii. The pensioner has 15 or more years of qualifying time and attained age 65 at the time of retirement.
- b. **Disability Retirement:** A participant shall be eligible for Basic Benefits if s/he receives disability pension benefits from the SIU Pacific District Pension Plan (which requires at least ten years of qualifying time at any age).
- c. **Dependents:** Spouses of eligible pensioners may submit medical expenses, including the spouse's Medicare Parts B and D premiums, for reimbursement under the pensioner's Annual Medical Benefit. Dependent children are not eligible for the Annual Medical and Hospital Benefits.
- d. **Surviving Spouse/Dependent:** Surviving spouses are entitled only to the Widow's benefit (i.e., not eligible for the Annual Medical and Hospital Benefit).

SPECIAL PENSIONERS BENEFIT

Participants with hire dates prior to August 1, 2000 in the following eligibility classes are eligible to receive benefits under the Special Pensioners Benefit:

- a. A participant eligible for the Annual Medical and Hospital Benefit; or
- b. A participant receiving payments for a Deferred Vested pension under the SIU Pacific District Pension Plan who retires from active service within 12 months of his/her last ship date; or
- c. A retired SUP member who is receiving a Chevron or San Francisco Bar Pilot pension and was a dues-paying member while employed and had some covered employment from participating employers in the SUP Welfare Plan; or
- d. All future pensioners in the categories (a) through (c), above, who are now active Plan members, and who qualified under the five-year vesting rule as of the end of the 1999/2000 Plan year (i.e., July 31, 2000); or
- e. Spouses of participants in categories (a) through (d), above.

BURIAL BENEFIT

If a Pensioner had been receiving pension payments from the SIU Pacific District Pension Plan prior to his death, a burial allowance equal to the cost of the Pensioner’s burial is payable to the person who provides for the burial. The burial allowance will be prorated according to the Pensioner’s qualifying pension contributions subject to a \$1,000 maximum. To determine how much is payable, please contact the Plan Office.

HOSPITAL COMFORT BENEFIT

If a Pensioner is admitted to a Hospital on an in-patient basis, the Plan will pay a daily allowance of \$4.00. This benefit will be payable as long as the Pensioner is confined and may be used for expenses incurred for personal needs and comfort.

PHS REPLACEMENT PROGRAM

Eligibility will continue under the PHS Replacement Program for Pensioners who are classified as permanently unfit for duty and have a Disability Pension from the SIU Pacific District Pension Plan and who have received a disability award from a Plan physician. Eligibility will terminate when the Pensioner becomes eligible for Medicare.

**ANNUAL MEDICAL AND HOSPITAL BENEFIT
SPECIAL MEDICAL PENSIONERS BENEFIT**

For a Pensioner who incurs expenses for hospital, medical, surgical, dental, prescription drug or vision care and treatment, the Plan will pay the maximum benefits specified below in any 12-month period ending July 31. This includes reasonable charges for actual expenses by any Hospital or Facility. The Plan also reimburses monthly Medicare Part B and Part D premiums up to the maximum benefits as stated herein.

ANNUAL MEDICAL AND HOSPITAL BENEFIT

Eligible Pensioners and their spouses can receive an annual benefit of up to \$2,000 per family (those who receive less than a full pension get a prorated portion of the \$2,000). The benefit can be used to pay claims for medical, drug, dental, or vision services, or be used to reimburse for supplemental medical coverage purchased by the covered individuals, including paying Medicare Parts B and D premiums.

The Medicare Part B premium reimbursement is paid to you on your pension check and deducted from your Annual Medical and Hospital Benefit Allowance. The Plan will also reimburse the premiums for the Pensioner’s spouse.

SPECIAL MEDICAL PENSIONERS BENEFIT

Eligible Pensioners and their spouses can receive an annual benefit of up to \$ 5,000 per family (those who receive less than a full pension get a prorated portion of the \$ 5,000). It can be used to pay claims for medical, drug, dental, or vision services, or be used to reimburse for supplemental medical coverage purchased by the covered individuals, including paying Medicare Parts B and D premiums. Benefit payments are subject to the following annual limits:

Eligible Premiums	\$ 3,000
Prescription Drug Expenses	1,000
Other	1,000

Under the Annual Medical and Hospital Benefit Allowance and Special Medical Pensioners Benefit, payment is charged to the benefit year based upon the date of service, not the date received or the date paid at the Plan Office. The Plan will not pay a benefit for any of the following charges:

1. Charges incurred on behalf of any other person except the Pensioner or Pensioner's spouse.
2. Charges incurred in any treatment, surgery or appliance for cosmetic purposes only or which have not been prescribed by a duly licensed physician or surgeon for medical or therapeutic care or treatment necessary because of non-occupational illness or bodily injury due to a non-occupational accident.
3. Charges incurred for any disability due to alcoholism.
4. Charges incurred for any disability due to mental or nervous disorders.
5. Charges incurred for treatment by a chiropractor except when such treatment is prescribed by a duly licensed Physician.
6. Charges incurred for acupuncture treatment except when such treatment is prescribed by a duly licensed physician.
7. Charges for services or supplies in excess of the Usual, Customary and Reasonable charges for such services or supplies that are generally charged for the particular geographical area in which the services or supplies were provided.

In addition, the following limitations and exclusions apply to Vision Care Benefits and Dental Benefits UP TO THE MAXIMUM.

Vision Care Benefits

In no event will any Optical Benefits paid by the Plan exceed the Usual, Customary and Reasonable charges for the service or supplies that are generally charged in the particular geographical area where the services or supplies are provided.

Limitations

1. One eye examination for eyeglasses once every Plan Year.
2. One pair of eyeglasses, single vision or bifocal lenses, including frames, once each Plan Year.

Services and supplies for the foregoing must be provided by a licensed optometrist, ophthalmologist or optician.

Exclusions

1. Frames that require oversize lenses.
2. Coated/tinted lenses.
3. Blended lenses.
4. Photochromatic lenses, extra tinted lenses or sunglasses, unless specifically prescribed for medical reasons.
5. Hard or soft contact lenses unless specifically prescribed for medical reasons or for visual acuity not obtained with regular spectacle lenses.

Special Lenses

In cases where a special type of lenses may be required because of a previous eye operation or a particular illness, the Plan will pay the Usual, Customary and Reasonable charges for such lenses provided that:

1. The lenses are provided by a licensed ophthalmologist; and

2. Approval for such lenses is given by the Plan Office prior to any purchase being made.

Dental Benefits

In no event will any Dental Benefit paid by the Plan exceed the Usual, Customary and Reasonable charges for the services or supplies that are generally charged in the particular geographical area where the services or supplies are provided.

Limitations

1. Replacement of partials and full dentures or other prosthodontic appliances once every three years, except when replacement is necessary for reasons of health, i.e., excessive tissue change, extensive loss of remaining teeth or changes in supporting tissues.
2. Crowns, jackets and gold restoration of the same tooth or teeth once every five years.

Should prosthodontic appliances be faulty and require replacement, the Plan will pay for the necessary replacement of such unsatisfactory appliances up to the Annual Medical and Hospital Allowance maximum benefit amount available to you for the Plan Year.

WIDOW'S BENEFIT

If at the time of a Pensioner's death, he was receiving a pension payment from the SIU Pacific District Pension Plan and had a legal spouse (as defined by this Plan) living and being supported by him, the Plan will pay the spouse the following:

1. If the Pensioner rejected the Joint Pensioner-and-Spouse Survivor option from the SIU Pacific District Pension Plan, this Plan will make a monthly Widow's Benefit payment to the surviving spouse for twelve consecutive months in an amount based on that portion of the Pensioner's SIU Pension qualifying years for which contributions were made by an employer to the SUP Welfare Plan, Inc.
2. If the Pensioner elected the Joint Pensioner-and-Spouse Survivor option from the SIU Pacific District Pension Plan, the surviving spouse (provided it is the person to whom the Pensioner was married at the time of the election) will receive a monthly pension payment from the SIU Pacific District Pension Plan in the amount established at the time of retirement for life. In addition, the surviving spouse will receive a Widow's Benefit payment for 12 consecutive months from the SUP Welfare Plan, Inc., in an amount based on that portion of the Pensioner's SIU Pacific District Pension qualifying years for which contributions were made by an employer to the SUP Welfare Plan.

If prior to the Pensioner's death, he had been receiving a disability pension, the monthly Widow's Benefit will include an additional amount equal to \$25 for each dependent child under age 18. As soon as the dependent child reaches age 18, the Widow's Benefit will be reduced by \$25 on the first of the month following the date when the child reaches the age of 18.

GENERAL PROVISIONS

PROOF OF CLAIM

All benefits for benefits not provided pursuant to an insurance contract are payable upon receipt by the Plan Office of written proof satisfactory to the Trustees covering the occurrence, character, and extent of the event for which claim is made on a form provided by or satisfactory to the Trustees.

EXAMINATION

The Trustees or their duly appointed representative will have the right and opportunity to examine the person of an Employee or Dependent during the pendency of a claim.

DIRECT PAYMENT BENEFITS - NOTICE OF CLAIM

Claims for Direct Payment Plan benefits must be filed at the Plan Office within three months following the first day of medical care, otherwise benefits will be payable only for the period, if any, beginning three months prior to the date when the claim is filed.

The Trustees may, at their discretion, extend the above time limit in the event evidence is produced in a form satisfactory to the Trustees that it was not reasonably possible to furnish timely proof.

Except as limited above, all Plan rules, benefits, limitations or exclusions will be applied to each claim filed on the basis of the date expense was incurred for which the claim is made.

In no event will benefits paid by this Plan exceed the Usual, Customary and Reasonable charge for the service or supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned.

PAYMENT OF CLAIMS

Benefits are payable to the eligible Employee or Pensioner or Dependent, or in the case of death benefits, the designated Beneficiary, provided however, that the Trustees, in their discretion, may pay such benefits to a Hospital or Physician furnishing services, supplies, care or treatment for benefits which are payable, or reimbursement to any person, including a Dependent, who has paid the Hospital or Physician for such services, supplies, care or treatment. Such payments will constitute a full discharge of the liability of the Trustees and Plan to the extent of the benefits so paid.

LIMITATION OF ACTION

No action at law or in equity will be brought to recover under this Plan prior to the exhaustion of the Appeals Procedure to the right, nor will such action be brought at all unless brought within one year after the date of loss upon which the cause of action is based.

NON-ASSIGNMENT OF BENEFITS

With the exception of medical benefits assigned to a Hospital or Physician, no eligible Employee, Pensioner, Dependent, or beneficiary will have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate a benefit payment hereunder. Benefits are not subjected to any legal process or levy execution upon or attachment or garnishment proceedings against for the payment of any claims.

CLAIMS AND APPEALS PROCEDURE

The claims and appeals procedure described below will apply to claims and appeals over which the Board of Trustees has discretion, including Direct Payment Plan medical, Direct Payment Plan dental, Direct Pay Reimbursement, vision, hearing aid, alcohol/substance abuse rehabilitation, temporary disability, and disability rehabilitation claims. Except for questions of eligibility under the Plan, the Board of Trustees do not have any say over benefit determinations made by an HMO, prepaid dental provider, service organization or an insurance carrier. Claims for benefits under such arrangements must be pursued using the claims and appeals procedures provided by such HMO, prepaid dental provider, service organization or insurance carrier. **DO NOT USE THE SUP WELFARE PLAN, INC CLAIMS AND APPEALS PROCEDURE.** For such claims, please read the provider's Evidence of Coverage or Insurance Policy for the claims and appeals procedure applicable to the benefit.

No Participant or other beneficiary will have any right or claim to benefits under the Plan or from the Plan, except as specified in the Trust Agreement. Any dispute as to eligibility, type, amount or duration of benefit under the Plan or any amendment or modification thereof will be resolved by the Board of Trustees under and pursuant to the Plan and the Trust Agreement, and its decision of the dispute is final and binding upon all parties to the dispute. No action may be brought for benefits provided by the Plan or any amendment or modification thereof, or to enforce any right there under, until after the claim therefore has been submitted to and determined by the Board of Trustees.

FILING A CLAIM

You or your authorized representative may file a Direct Payment Plan medical, Direct Payment Plan dental, Direct Pay Reimbursement, vision, hearing aid, alcohol/substance abuse rehabilitation, temporary disability, or disability rehabilitation claim by contacting the Plan Office at (415) 778-5490. The Plan Office will provide you with further instructions for filing your claim. The Plan may also require you to provide an authorization certifying that you have authorized another individual to act on your behalf (i.e., your "authorized representative") in pursuing a claim or appeal.

Claims must be filed at the Plan Office within three months following the first day of care, otherwise benefits will be payable only for the period, if any, beginning three months prior to the date when the claim is filed. The Trustees may, at their discretion, extend the above time limit in the event evidence is produced in a form satisfactory to the Trustees that it was not reasonably possible to furnish timely proof.

Upon receipt of your claim, the Plan will categorize the claim as a Post- Service Claim, an Urgent Care Claim, a Pre-Service Claim, a Concurrent Care Claim, or a Disability Claim. The categorization of your claim will dictate the Plan's time frame for responding to your claim. **PLEASE NOTE THAT MOST OF YOUR CLAIMS WILL BE POST-SERVICE CLAIMS.**

A **Post-Service Claim** is any claim for reimbursement of payments you have made for services or care you have already received. A Post-Service Claim is also any claim that is not an Urgent Care Claim, a Pre-Service Claim, or a Concurrent Care Claim.

An **Urgent Care Claim** is any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

You may make a verbal request to the Plan Office for determination on an Urgent Care Claim or submit an Urgent Care Claim in writing to the Plan Office. A physician or other health care professional who has knowledge of your medical condition may act as your authorized representative. Such physician or health care professional need not be certified as your "authorized representative".

You may be asked to explain or describe whether and what medical circumstances exist that may give rise to a need for expedited processing of your claim, i.e., what medical circumstances exist that make your claim an Urgent Care Claim.

A **Pre-Service Claim** is any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit prior to the receipt of care.

The only Plan benefit that requires approval of the Plan in advance of receiving care is the alcohol/substance abuse rehabilitation benefit. In other words, before you can be admitted to a facility for alcohol and/or drug abuse rehabilitation benefits, you must first receive preauthorization from the Plan Office.

Although the Plan maintains a voluntary preauthorization process for dental claims, you are not required to seek approval from the Plan Office prior to receiving care; consequently, the rules regarding Pre-Service Claims do not govern dental claims.

A **Concurrent Care Claim** is a claim for ongoing care or treatment plan that has been reviewed and approved by the Plan. Examples include physical therapy or chiropractic care for which a treatment program would include a limited number of visits and an alcohol/substance abuse rehabilitation admission for which a particular length of stay has been approved by the Plan.

A **Disability Claim** is a claim for a temporary disability benefit as described on page 35 of the SPD or a claim for a monthly allowance rehabilitation benefit as described on page 38 of the SPD.

Time Frames for Initial Decision Making

Post-Service Claim

If you submitted a Post—Service Claim and the Plan denies your claim in whole or in part, the Plan Office will provide you with written notice of the Plan's benefit determination in the form of an Explanation of Benefits within **30** days of the Plan's receipt of your claim, unless circumstances beyond the control of the Plan require an extension of time. If an extension is required, you will be given written notice of the extension prior to the termination of the initial **30** day period. The extension will not exceed **15** days from the end of the initial period.

In the event that an extension is necessary because you failed to submit information necessary to decide your claim (including the report of a required medical examination), your written notice of the extension will specifically describe the required information. The time period for making a benefit decision will also be suspended until the earlier of the Plan's receipt of all the requested information or the date established by the Plan for the furnishing of the information (**45** days or other longer period specified in the Plan's notice). A decision will be made on your claim within **15** days after you respond to the request for additional information or within **15** days after the end of the deadline given to provide additional information, whichever is earlier.

Urgent Care Claims

If you properly submitted an Urgent Care Claim with all the necessary information, the Plan Office will provide you with written notice of its benefit determination as soon as possible, taking into account medical needs, but not later than **72** hours after the Plan's receipt of your claim. However, if you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Office will notify you within **24** hours after the Plan's receipt of your claim of the specific information necessary to complete your claim. You must provide the specified information within

48 hours (or any longer period specified in the Plan's notice). Thereafter, the Plan Office will notify you of the Plan's benefit determination no later than **48** hours after the earlier of the Plan's receipt of the specified information, or the end of the period given to you to provide the specified additional information.

If you fail to follow the procedure for filing an Urgent Care Claim, you will be notified of the failure and the proper procedures to be filed as soon as possible, but not later than **24** hours after the Plan's receipt of the improper claim. You may be notified orally, in which case a confirmation letter will be sent in writing within three days of the oral notice. You will receive a notice if the claim or your communication to the Plan Office fails to include any of the following information: a) the name of the specific claimant, b) the specific medical condition or symptom, and c) the specific treatment, service, or product for which Plan approval is requested.

Pre – Service Claims

If you properly submitted a Pre-Service Claim (i.e., you requested preauthorization from the Plan Office for an alcohol/substance abuse rehabilitation benefit) with all the necessary information, the Plan Office will provide you with written notice of the Plan's determination within **15** days of the Plan's receipt of your claim, unless circumstances beyond the control of the Plan require an extension of time. If an extension of time is required, you will be given written notice of the extension prior to the termination of the initial **15** day period. The extension will not exceed **15** days from the end of the initial period.

In the event that an extension is necessary because you failed to submit information necessary to decide your claim, your written notice of the extension will specifically describe the required information. The time period for making a benefit decision will also be suspended until the earlier of the Plan's receipt of all the requested information or the date established by the Plan for the furnishing of the information (**45** days or other longer period specified in the Plan's notice). A decision will be made on your claim within **15** days after you respond to the request for additional information or within **15** days after the end of the period specified in the notice for providing additional information, whichever is earlier.

If you fail to follow the procedure for Pre-Service Claims, you will be notified of the failure and the proper procedures to be filed as soon as possible, but not later than **5** days following the failure. You may be notified orally, unless you request written notification. You will receive a notice for failing to follow the proper procedure for filing a claim if the claim is not received by the Plan Office of if your communication to the Plan Office fails to include any of the following information: a) the name of the specific claimant, b) the specific medical condition or symptom, and c) the specific treatment, service, or product for which Plan approval is requested.

Concurrent Care Claim

If the Plan approved an ongoing course of treatment to be provided over a period of time or number of treatments and there is a reduction or termination of the course or number of treatments before the end of the period of time or number of treatments, the Plan Office will notify you sufficiently in advance of the reduction or termination to allow you to appeal the decision before the benefit is reduced or terminated.

If you request an extension of a previously approved ongoing course of treatment or number of treatments and the request is also an Urgent Care Claim, the Plan Office will provide you with notice of its determination within **24** hours after the Plan's receipt of the claim, provided the claim is made to the Plan at least **24** hours prior to the expiration of the prescribed period of time or number of treatments.

Disability Claim

If you submitted a Disability Claim and your claim was denied in whole or in part, the Plan Office will notify you in writing of its denial within **45** days of the Plan's receipt of your claim, unless circumstances beyond the control of the Plan require an extension of time. If an extension is required, you will be given written notice of the extension prior to the termination of the initial **45** day period. The extension will not exceed **30** days from the end of the initial period (i.e., 75 days from the date the plan initially received the claim.). If, at the end of the first extension period, a second extension of time is necessary due to matters beyond the control of the plan, written notice of the extension will be furnished to you prior to the end of the first

30 day extension period. The second extension will not exceed **30** days from the end of the first extension period (i.e., **105** days from the date the plan initially received the claim.)

If an extension is necessary because you failed to provide information necessary to decide your claim, your written notice of the extension will specifically describe the required information. The time period for making a benefit decision will also be suspended until the earlier of the Plan's receipt of all the requested information or the date established by the Plan for the furnishing of the information (**45** days or other longer period specified in the Plan's notice). A decision will be made on your claim within **30** days after you respond to the request for additional information or within **30** days after the end of the deadline given to provide additional information, whichever is earlier.

Notification Requirements For An Initial Claim

If your Direct Payment Plan medical, Direct Payment Plan dental, Direct Pay Reimbursement, vision, hearing aid, alcohol/substance abuse rehabilitation, temporary disability, or disability rehabilitation claim is denied in whole or in part, the Plan Office will provide you with a notice of the adverse determination that includes the following information:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- a description of the Plan's appeal procedure and the time limits applicable to such procedures;
- a statement regarding your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If your Urgent Care Claim is denied, the notice will also include a description of the Plan's expedited appeal procedure.

FILING AN APPEAL

Right of Appeal Language for Group Health Plan Claim Denial Notices/EOB

If you disagree with the Plan's determination, you or your authorized representative may appeal the determination to the Board of Trustees. Your appeal must be in writing and must be received by the Plan no later than 180 days after you receive this notice. If your claim involves the provision of urgent care and the Plan has characterized your claim as an "Urgent Care Claim", you may submit your appeal orally or in writing.

Your appeal should include specific facts and benefit plan provisions that support your claim for benefits. You may also present written comments, documents, records, and other information that support or relate to your entitlement to benefits under the Plan. Moreover, you may request to examine and/or obtain copies of, all documents, records, and other information relevant to your claim for benefits free of charge.

The Board of Trustees will notify you of its determination on appeal as soon as possible, but not later than 5 days after the next regularly scheduled Board of Trustees meeting, unless the appeal is filed less than 30 days before the next meeting. In such case, the Board of Trustees will notify you no later than 5 days after the second Board of Trustees meeting following the Plan's receipt of your request for review. If special circumstances require a further extension of time for processing, the Board of Trustees will notify you of its determination no later than 5 days after the third meeting of the Board of Trustees following the Plan's receipt of your request for review. The Board of Trustees will provide you with a written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension.

If you submitted an appeal of a denied Urgent Care Claim or a Concurrent Care Claim that is also an Urgent Care Claim, the Plan will notify you of its decision within 72 hours after the Plan's receipt of your appeal.

If you submitted an appeal of a denied Pre-Service Claim or a Concurrent Care Claim for benefits that requires the Plan's prior approval and that does not involve urgent medical care or treatment, the Plan will notify you of its decision not later than 30 days after the Plan's receipt of your appeal.

If your appeal is denied by the Board of Trustees, you have the right to bring a civil action under Section 502(a) of ERISA within one year after the date of loss upon which the cause of action is based..

If your appeal involves an Urgent Care Claim, all necessary information, including the Board of Trustees' decision, will be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

Time Frames for Decision Making on Appeal

Post-Service/Concurrent Care Claim

If you submitted an appeal of a denied Post-Service Claim or an appeal of a reduction or termination of a previously approved course of ongoing treatments or number treatments, the Board of Trustees will notify you of its determination on appeal as soon as possible, but not later than 5 days after the next regularly scheduled Board of Trustees meeting, unless the appeal is filed less than 30 days before the next meeting. In such case, the Board of Trustees will notify you no later than 5 days after the second Board of Trustees meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, the Board of Trustees will notify you of its determination no later than 5 days after the third meeting of the Board of Trustees following the Plan's receipt of the request for review. The Board of Trustees will provide you with a written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension.

Urgent Care Claim/Concurrent Care Claim

If you submitted an appeal of a denied Urgent Care Claim or a Concurrent Care Claim that is also an Urgent Care Claim, the Plan will notify you of its decision within 72 hours after the Plan's receipt of your appeal.

Pre-Service Claim/Concurrent Care Claim

If you submitted an appeal of a denied Pre-Service Claim or a Concurrent Care Claim for benefits that requires the Plan's prior approval and that does not involve urgent medical care or treatment, the Plan will notify you of its decision no later than 30 days after the Plan's receipt of your appeal.

Disability Claim

If you submitted an appeal of a denied Disability Claim, the Board of Trustees will notify you of its determination on appeal as soon as possible, but not later than **5** days after the next regularly scheduled Board of Trustees meeting, unless the appeal is filed less than **30** days before the next meeting. In such case, the Board of Trustees will notify you of its determination on appeal no later than **5** days after the second Board of Trustees meeting following the Plan's receipt of the appeal. If special circumstances require a further extension of time for processing, the Board of Trustees will notify you of its determination no later than **5** days after the third meeting of the Board of Trustees following the Plan's receipt of the appeal. The Board of Trustees will provide you with a written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension.

Additional Rights on Appeal

If you choose to pursue an appeal, you will have the following rights:

- You will have the opportunity to submit written comments, documents, records, and other information relating to your claim to the Board of Trustees;
- You will have the opportunity to request reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits free of charge;
- The appeal will take into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- The reviewer, i.e., the Board of Trustees will consider the full record of the claim and will independently make a determination;
- The appeal will be conducted by a named fiduciary who is neither the individual who made the initial adverse determination, nor the subordinate of such individual;
- If the denial is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the named fiduciary will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment;
- The health care professional consulted on appeal will not be the individual consulted in connection with the initial denial nor the subordinate of any such individual; and
- You may request the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial denial, without regard to whether the advice was relied upon in making the benefit determination.

You do not have the right to appear before the Board of Trustees personally. The Board of Trustees may authorize a hearing if it determines that a hearing would be of assistance in its deliberation.

Notification Requirements For Denial on Appeal

If the Board of Trustees denies your appeal, the Board of Trustees will provide you with a notice of the adverse determination that includes the following information:

- the specific reason or reasons for the adverse determination;
- a reference to the specific plan provisions on which the benefit determination is based;
- a statement regarding your entitlement to request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- a statement of your right to bring an action under section 502(a) of ERISA;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If you have any questions regarding the above procedures, please contact the Plan Office at (415) 778-5490.

DEFINITIONS

The following terms are used throughout this booklet and their definitions will help you understand your benefit plan.

1. **Accident or Accidental Injury** means an unexpected event occurring through external and violent means not necessarily involving another person.
2. **Board of Trustees** means the Board of Trustees established pursuant to the Trust Agreement.
3. **Collective Bargaining Agreement** means a Collective Bargaining Agreement between the Sailors' Union of the Pacific and any company that is obligated to contribute to the SUP Welfare Plan.
4. **Covered Benefit** means only those benefits mentioned and it excludes benefits not mentioned or listed as Exclusions.
5. **Covered Charges or Covered Expenses** means the charges or expenses incurred by a Participant while eligible under the Plan, which are:
 - a. Expressly covered under the applicable provisions of the Plan; and
 - b. Medically necessary; and
 - c. Usual, Customary and Reasonable, but not to exceed allowances expressly provided under the Plan or the amount charged.
6. **Dentist** means any doctor licensed to practice Dentistry.
7. **Dependent** means an individual who is one of the following:
 - a. The Employee's lawful spouse;
 - b. The Employee's children from birth to age 26 years of age. The definition of children includes your natural children, stepchildren, legally adopted children, and children placed for adoption who are dependent upon you for support and maintenance and are listed on your enrollment card in the Plan Office. Children who are required to be covered by the Employee by a Qualified Medical Child Support Order (QMCSO) are also covered. Foster children or children for whom you have been legally appointed guardian are not eligible as dependents. The attainment of the limiting ages specified above will not affect termination of coverage of such child while the child is and continues to be both:
 - (1) Incapable of self-sustaining employment by reason of mental or physical handicap; and
 - (2) Chiefly dependent upon the Employee for support and maintenance, provided that the Dependent remains disabled and unmarried, and written evidence of such incapability is furnished to the Plan Office by the Employee within 31 days after the child attains the maximum age and subsequently as may be required by the Trust, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.
 - c. An eligible Employee may designate his parent or parents as his Dependents providing that at the time of occurrence of claim involving such parent:

- (1) The eligible Employee does not have a spouse or child who falls within the definition of Dependent as defined within the Plan Rules and Regulations; and
- (2) The parent or parents are not eligible for Medicare by age or medical condition and have been designated by the eligible Employee as his Dependent or Dependents have been claimed as Dependents for tax exemption purposes in the Employee's Federal Income Tax Return for the calendar year preceding the date on which a claim is incurred.

The Plan Office, at its discretion, may require documents to establish responsibility for coverage of these Dependents including, but not limited to Income Tax forms, Adoption Papers, Divorce Decree, Marriage Certificate, Birth Certificate or any provider requirement.

The term Dependent does not include any lawful spouse or child who is in full-time military service.

8. **Disabled** means that an eligible Employee is prevented, solely because of injury or disease, from engaging in his regular and customary occupation. For all other covered eligibles, Disabled means the eligible is under a Physician's care due to injury or disease and is not able to do substantially all the normal activities of a person of like age or sex who is in good health and is not engaged in any occupation or business for income or profit.
9. **Doctor or Physician** means any Physician or Surgeon (M.D.), Podiatrist (DPM) and Doctor of Osteopathy (D.O.) licensed to practice medicine in the State in which he or she practices. The term Doctor will also include an advanced nurse practitioner (a certified nurse practitioner, nurse-midwife or Physician Assistant) if the following requirements are met:
 - a. The service is otherwise covered under the Plan;
 - b. The service of the advanced nurse practitioner is in lieu of the service of a Physician;
 - c. The service is within the lawful scope of the provider's license; and
 - d. The provider is performing services under the supervision of a duly Licensed Physician, if such supervision is required.
10. **Drugs or Prescription Drugs** means any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it. Such items must have FDA approval for treatment of the condition for which they are prescribed.
11. **Employee** means any person employed under a Collective Bargaining Agreement between the Employer and the Union and on whose account the Employer is making, or is obligated to make, contributions into this Plan.
12. **Employer** means any company that is obligated by a Collective Bargaining Agreement to contribute to the SUP Welfare Plan. The Union is considered an Employer for the purposes of permitting the Union to contribute on behalf of its Employees.
13. **Experimental** means a drug, device, medical treatment or procedure that:
 - a. Is under investigation, limited to research or restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies; or

- b. The drug, device, medical treatment or procedure or the patient informed consent document utilized with it was reviewed and approved by the treating facility's institutional review board or federal law requires such review or approval; or
 - c. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
 - d. Reliable Evidence shows that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis. Reliable Evidence means ONLY:
 - (1) published reports and articles in authoritative medical and scientific literature; or
 - (2) the written protocol(s) used by the treating facility or another facility studying substantially the same item or treatment; or
 - (3) the written protocol(s) used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure.
14. **Hospital** means a state or federally licensed institution which meets all of the following requirements:
- a. It is engaged primarily in providing diagnostic, surgical and therapeutic facilities for medical and surgical care of sick and injured persons on an inpatient basis at the patient's expense;
 - b. It continuously provides 24-hour a day supervision by a staff of Physicians licensed to practice medicine (other than Physicians whose license limits their practice to one or more specified fields) and 24-hour a day nursing care by or under the supervision of Registered Nurses (RN);
 - c. It is not, other than incidentally, a birthing center, a place of rest, a nursing home, convalescent home, a place for the aged, pain clinic, a place for drug addicts, a place for alcoholics, or similar institution.
15. **Medically Necessary**, with respect to services and supplies received for treatment of an illness or injury, means those services or supplies determined to be:
- a. Appropriate and necessary for the symptoms, diagnosis or treatment of the illness or injury; and
 - b. Provided for the diagnosis or direct care and treatment of the illness or injury and
 - c. Within standards of good medical practice within the organized medical community; and
 - d. Not primarily for the convenience of the patient, the patient's Physician or another provider; and
 - e. The most appropriate supply or level of service which can safely be provided. For Hospital confinement, this means that acute care as a bed patient is needed due to the kind of services the patient is receiving or the severity of the patient's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

16. **Mental Disease, Disorder or Condition** means any nervous or mental disease or disorder (whether the cause is organic, physical, mental, environmental, or a combination thereof, or whether the symptoms are physical, mental, or a combination thereof), including, but not limited to: schizophrenia, manic depression or other conditions usually classified in the medical community as psychosis; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; autism; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; post traumatic stress disorder; cumulative trauma syndrome; organic brain syndrome; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia and bulimia.
17. **Participant** means any Employee, Dependent or beneficiary eligible for benefits under the Plan.
18. **Pensioner** means any person who meets the eligibility requirements on page 38.
19. **Pharmacist** means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.
20. **Protected Health Information (“PHI”)** means individually identifiable information that is created or received by the Trust Fund, whether in oral, written, or electronic form, that relates to (i) the past, present or future physical or mental health or condition of a participant or dependent; (ii) the provision of health care to a health plan participant or dependent; or (iii) the past, present or future payment for the provision of health care to a participant or dependent. Health information becomes individually identifiable when it either identifies the participant or dependent or provides a reasonable basis to believe the information can be used to identify the participant or dependent. The following items may cause health information to become individually identifiable: i) name; ii) street, city, county, precinct, zip code; iii) dates directly related to a participant’s or dependent’s receipt of health care treatment, including birthdate, health facility admission and discharge date, or date of death; iv) telephone numbers, fax numbers, and electronic mail addresses; v) social security numbers; vi) medical record numbers; vii) account numbers; viii) certificate/license numbers; ix) vehicle identifiers and serial numbers, including license plate numbers; x) device identifiers and serial numbers; xi) Web Universal Resource Locators (URLs); xii) internet protocol (IP) address numbers; xiii) biometric identifiers, including finger and voice prints; xiv) full ace photographic images and any comparable images; and xvi) any other unique identifying number, characteristic or code.
21. **Relative** means the Employee’s spouse, child, father, mother, stepmother, stepfather, stepchildren, brother, sister, halfbrother, halvesister, niece, nephew, aunt, uncle, grandmother, grandfather or grandchildren.
22. **Summary Health Information** means health information that may identify a health plan participant or dependent, and (i) summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the health plan; and (ii) from which the information described at 42 CFR section 164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.
23. **Union** means the Sailors’ Union of the Pacific.
24. **Usual, Customary and Reasonable (UCR)** means the fee charged for a service by a provider of service within a particular geographical area which meets the following criteria, as determined by the Board of Trustees in its sole discretion:
 - a. **Usual** means the charge the provider most frequently makes to the majority of his or her patients for a given service.

- b. Customary means the charge is within the range of the usual charges made by other providers of similar training and experience for the same service within a similar geographic area.
- c. Reasonable means the service is within reasonable utilization limits, and is justifiable considering the circumstances involved, in the opinion of responsible medical authorities (such as a medical association review committee).

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