SUP WELFARE PLAN, INC.

SUMMARY PLAN DESCRIPTION FOR ACTIVE PARTICIPANTS & PENSIONERS

AUGUST 1999

SUP WELFARE PLAN, INC.

Vern Johansen,
Administrator
450 Harrison Street
San Francisco, CA 94105
(415) 778-5490

BOARD OF TRUSTEES

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The Segal Company


SAILORS' UNION
S.U.P.
ORG. 1885
OF THE PACIFIC

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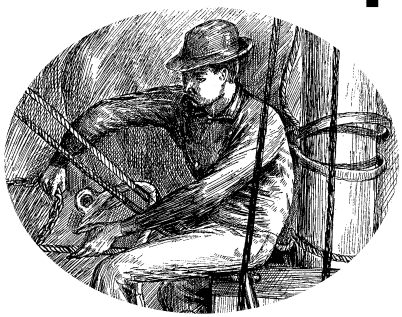
Dear Participant:



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.

We urge you and your family to read this booklet thoroughly so that you will be familiar with the benefits of the Plan.

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, or Employer representative is authorized to interpret this Plan on behalf of the Board or to act as an agent of the Board. 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 Trustees in their sole discretion may amend the Plan by a majority vote of the Trustees. 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 ADMINISTRATOR

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PLAN SPONSOR

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

EMPLOYER IDENTIFICATION NUMBER

94-1243666

PLAN NUMBER

502

FISCAL YEAR BEGINNING

August 1

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 page 7.

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 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 page 7.

The medical, drug, and dental benefits described in this booklet that are not provided through the prepaid providers and the death benefits are self-funded. All claims presented by Plan Participants are computed and reimbursed by the Administrator.

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.

TYPE OF PLAN

This is a health care plan providing the following benefits for Employees and their Dependents who are eligible for them:

- Death and Burial Benefits
- Hospital, Medical and Surgical Benefits
- Dental Benefits
- Vision Care Benefits
- Prescription Drug Benefits
- Hearing Aid Benefits
- Temporary Disability Benefit
- Training Benefits
- Alcohol/Substance Abuse Rehabilitation Benefits
- Rehabilitation Benefit

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.

If you have a dispute regarding a claim for benefits, see the "Appeals Procedure" on pages 77 and 78.

COLLECTIVE BARGAINING AGREEMENT

The Plan is maintained pursuant to Collective Bargaining Agreements between the Sailors' Union of the Pacific and various 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

Eligibility for benefits is described in this Plan Booklet beginning on page 21.

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 21-29, 31-32, 35-41, 43-57, 67-70 and 73-78.

FUNDING MEDIUM

The Plan is financed by Employer contributions pursuant to the Collective Bargaining Agreements. A supplemental source of financing is interest earned on the investment of reserve funds and voluntary contributions of Participants to retain eligibility.

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 be 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.

CLAIMS AND APPEALS PROCEDURES

The procedures for filing a claim or appealing a denial vary according to the benefit. Please refer to pages 76-78.

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 provides that all Plan Participants are entitled to:

a. Examine, without charge, at the Administrative Office and at local Unions, 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.

b. Obtain, upon written request to the Board of Trustees or the Administrative Office, 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. A reasonable charge may be made for the copies.

c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

d. 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. Your or your dependents may have to pay for such coverage.

e. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a 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 consider 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 a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. 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. If you have any questions about your Plan, you should contact the Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory, or the division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. 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.

SUMMARY OF BENEFITS AND OTHER IMPORTANT BENEFIT PROVISIONS

ACTIVE EMPLOYEE BENEFITS

DEATH BENEFIT
$25,000; available to Employees who have one day of seagoing employment in the 365 days immediately preceding the date of death.

BURIAL BENEFIT
$500; available for Employees who do not meet the eligibility requirements for the Death benefit, provided the Employee had at least 1,000 days of covered employment.

HOSPITAL COMFORT BENEFIT
$4 per day of hospital confinement for personal expenses; with PHS Replacement Program eligibility.

HOSPITAL ALLOWANCE
$12 per day of 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 CA SDI.

VISION CARE BENEFIT
$200 maximum for vision care expenses every two years.

HEARING AID BENEFIT
$400 maximum per ear, payable once every four years.

PUBLIC HEALTH REPLACEMENT PROGRAM MEDICAL AND DENTAL BENEFITS
Provided through Prepaid Medical and Prepaid Dental Plans with Plan reimbursement of certain co-payments and direct payment of qualified medical and dental expenses covered by the U.S. Public Health Service which are not provided by the Prepaid Plans.

ALCOHOL TREATMENT BENEFIT
Contract Provider only; reimbursed at 100%; limited to one treatment program per lifetime; second treatment program may be authorized by Trustees.

EMPLOYEE ASSISTANCE PROGRAM
Confidential assistance for drug and alcohol problems. Toll free telephone number: 24 hours, seven days a week.

TRAINING BENEFITS
Andrew Furuseth School of Seamanship. Provides assistance for mariners to obtain endorsements and maintain compliance for seagoing employment.

ACTIVE EMPLOYEES' DEPENDENT MEDICAL BENEFITS

(you may elect only one coverage option)

Prepaid Medical Plan...

Programs provided by PHS replacement program. Refer to pages 32-34 for provider listing.

...OR...Direct Payment Plan

BASIC MEDICAL BENEFITS

HOSPITAL

Room and Board: $130 per day, maximum of 35 days per disability

Hospital Services: $1,000 per disability

Ambulance: Up to $48 for services to or from Hospital

SURGERY

1964 Relative Value Study units times a Conversion Factor of $15; $3,000 maximum per disability

PHYSICIAN HOSPITAL VISITS

$15 per day, maximum of $525 per confinement

PHYSICIAN OFFICE/ HOME VISITS

$12 per visit, maximum of 35 visits per calendar year

MENTAL & NERVOUS OUTPATIENT PHYSICIAN VISITS

$12 per day, maximum of 20 visits per calendar year

DIAGNOSTIC X-RAY AND LABORATORY

$100 per calendar year for sickness; $100 per accident

PHYSICAL EXAMINATIONS

Provided by SIU-PD Seafarers Medical Center, or $75 per exam

SUPPLEMENTAL ACCIDENT BENEFIT

$300 maximum per accident

MAJOR MEDICAL BENEFITS

Deductible: $100 per calendar year

Coinsurance: 80% of Usual, Customary and Reasonable charges

Lifetime Maximum: $50,000

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

Programs provided by PHS Replacement Program

PENSIONER BENEFITS

BURIAL BENEFIT
Pro-rated according to qualifying pension contributions, $1,000 maximum

HOSPITAL COMFORT BENEFIT
$4 per day

PHS REPLACEMENT PROGRAM
For pensioners who are determined to be permanently unfit for duty by a Plan physician at retirement. Benefits cease when the pensioner becomes eligible for Medicare.

ANNUAL MEDICAL AND HOSPITAL BENEFIT
Pro-rated according to qualifying pension contributions, up to an $1,850 maximum per 12-month period ending July 31st of each year.

Annual Medical and Hospital Benefit pays reasonable and customary expenses up to the maximum amount for hospital, medical, prescription drug, vision and dental expenses and reimbursement of Medicare Part B premiums.

PENSIONER'S SPOUSE BENEFIT

MEDICARE PART B PREMIUM
Reimbursement of Medicare Part B premium (included in Pensioner's Annual Medical-Hospital Benefit).

WIDOW'S BENEFIT
Pays each widow a monthly benefit equal to the SIU pensioner's district pension that the Pensioner would have received; for 12 months or, if sooner, until death.

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

FEDERAL REQUIREMENTS FOR BENEFITS

SPECIAL RIGHTS UPON CHILDBIRTH

Group health plans 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 Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Note: Under the terms of the Plan, no benefit will be payable with respect to any hospital admission of a Dependent child on account of pregnancy, childbirth, miscarriage, or abortion except for involuntary complications of pregnancy.

SPECIAL RIGHTS CONCERNING MASTECTOMY COVERAGE

Under federal law, group health plans that provide coverage for mastectomies (yours does) 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 on or after the law's effective date (August 1, 1999 for this Plan), 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.

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.

Qualifying Period: The initial Qualifying Period for all benefits under this Plan provided for Employees and their eligible Dependents is any period of 365 consecutive days.

Initial Employment Requirement: The required number of days of Covered Employment, for which a contribution was made by the Employer during the Qualifying Period, will be as follows:

a. Any Active Seaman who has not been eligible for PHS Replacement Program benefits for 24 consecutive calendar months (excluding COBRA) must accumulate 120 days of covered employment in a 12 consecutive calendar month period to earn initial eligibility for himself and his eligible Dependents.

b. An Active Seaman who has been eligible for PHS Replacement Program benefits in the latest 24 consecutive month period may earn initial eligibility for himself and his eligible Dependents by accumulating 60 days of covered employment in a 12 consecutive month period.

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 or days of attendance at an approved SUP training school program.

Benefit Payments: No benefit is payable on the account of an eligible Dependent unless and until a current enrollment card provided by the SUP Welfare Plan has been filed by the Employee for such Dependent or Dependents with the Plan Office. The Plan Office from time to time may require a new enrollment card if deemed necessary by the Plan Office for the proper administration of benefit payments.

See page 79 for the definition of eligible Dependents.

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 60 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 card with the Plan Office.

CONTINUING ELIGIBILITY

The eligibility period for an Employee and his eligible Dependents who attain eligibility by covered employment will be the 365-day period next following the date initial eligibility was attained. Thereafter, the Employee's eligibility period will be extended on a continuing basis if he accumulates 60 days of covered employment during each 365-day period, provided his eligibility is continuous without a break of 24 months. Temporary Disability and Death benefits have different continuing eligibility requirements.

An Active Employee can also continue eligibility by one day of covered employment aboard a vessel if the Employee becomes injured during such covered employment and seeks medical care no later than 48 hours (excluding Saturdays, Sunday or holidays) after leaving the vessel and such injury is evidenced by a Physician's diagnosis.

Exceptions: The eligibility benefit period for an Employee who attains eligibility because of Not-Fit-For-Duty status is 180 days or until the day he becomes Fit-For-Duty, whichever occurs first.

SPECIAL EXTENSIONS OF ELIGIBILITY FOR DISABILITY

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

1. If an Employee remains in the industry 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 or until he becomes Fit-for-Duty, whichever occurs first.

2. If an 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 one year from the date he is declared Permanently-Not-Fit-For-Duty.

A member who becomes Not-Fit-For-Duty during a 180-day eligibility period will, upon becoming Fit-For-Duty, be entitled to a continuation of eligibility for three months from the date he became Fit-For-Duty or for the balance of his 180-day eligibility period remaining on the date he became disabled, whichever is greater.

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. End of the 365-day 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.

TERMINATION OF DEPENDENTS' COVERAGE

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

1. End of the 365-day eligibility period if not extended as set forth under the section entitled "Continuing Eligibility";
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
6. First day of the fourth calendar month immediately following the date of the Employee's death.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Recent changes in federal law may affect your health coverage if you are enrolled or become eligible in another plan that excludes coverage for preexisting medical conditions.

The Health Insurance Portability and Accountability Act of 1996 limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a preexisting condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a preexisting condition exclusion. Contact your State Insurance Department for further information.

You will lose your HIPAA rights regarding the restriction of preexisting condition exclusions if there has been a break of 63 days between your loss of coverage under the Plan, and your commencement of coverage under any new Plan, including COBRA coverage.

If you lose coverage under the Plan or under COBRA Continuation Coverage, you will receive a certificate of health coverage indicating the period of time you were covered under this Plan. Check with your new Plan Administrator to see if your new Plan excludes coverage for preexisting conditions and if you need to provide a certificate or other documentation of your previous coverage.

In addition, a certificate will be issued to you upon a request made within 24 months after coverage ceases under the Plan or COBRA Continuation Coverage. To request a certificate, please contact the SUP Welfare Plan Administrator at (415) 778-5490. This certificate must be provided to you promptly. Keep a copy of this completed form. You may also request a certificate for any of your dependents (including your spouse) who were enrolled under your health coverage.

COBRA CONTINUATION OF COVERAGE SELF-PAYMENT PROVISIONS

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

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan provides certain eligible Participants the federally mandated option of continuing their health care coverage on a limited basis after active coverage has terminated. Please contact the Plan Office to see if you qualify under this program. You and all of your Dependents should read this entire section carefully so that you understand this program.

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:

1. Insufficient days of employment;
2. Termination of employment through resignation, layoff, discharge, or retirement unless the Employee elects coverage under the Plan's Pensioner Program.

EMPLOYEES' DEPENDENT SPOUSE OR DEPENDENT CHILDREN

If a dependent spouse or dependent children, who is eligible for benefits, 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 79.

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

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 21-23 and 67. 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 prepaid medical plan and a prepaid dental plan of the Program, provided the Employee meets the requirements set forth by the provider. Once enrolled in a prepaid service plan, the Employee cannot change to another prepaid plan 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, Pacific Health Plans, Blue Cross/Blue Shield of Louisiana, Health Insurance Plan (HIP) of Greater New York, Health Net of California, Naismith Dental Group, Sakai Dental Group, Dental Health Services, Dental Care Centers of Hawaii, Delta Dental of California, and Dina Dental Plan—New Orleans. Addresses are listed on the following pages.

BENEFITS

Benefits provided by the prepaid provider are subject to the contract between the provider and the SUP Welfare Plan. Please refer to the applicable prepaid brochure for a list of covered services.

LIMITATIONS AND EXCLUSIONS

(In addition to those on page 36.)

No benefit is payable for services provided by a prepayment medical plan or dental plan in which an Employee is enrolled or is eligible to be enrolled.

SUP WELFARE PLAN

Directory of Contracted Providers

GROUP HEALTH COOPERATIVE OF PUGET SOUND

1730 Minor Avenue
P.O. Box 34750
Seattle, WA 98124-1750
Provides prepaid medical, drug and vision benefits to participants enrolled in GHC, with guaranteed payment of those benefits.

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.

HIP OF GREATER NEW YORK

7 West 34th Street
New York, NY 10001
Provides prepaid medical, drug and vision benefits with guaranteed payment of these benefits to participants enrolled in the HIP plan.

DENTAL CARE CENTERS OF HAWAII

95-1249 Meheula Parkway
Suite A-12
Milialani, HI 96789
Provides prepaid dental benefits with guaranteed payment of these benefits to participants enrolled in the Dental Care plan.

HEALTH NET OF CALIFORNIA

155 Grand Avenue
Oakland, CA 94612
Provides prepaid medical, drug and vision benefits with guaranteed payment of these benefits to participants enrolled in the Health Net plan.

KAISER FOUNDATION HEALTH PLAN, INC.

3288 Moanalua Road
Honolulu, HI 96819
Provides prepaid medical, drug and vision benefits with guaranteed payment of these benefits to participants enrolled in the Kaiser plan.

DENTAL HEALTH SERVICES

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.

HEALTH MANAGEMENT CENTER, INC.

7755 Center Avenue
Suite 100
Huntington Beach, CA 92647-3007
Administers the Employee Assistance Program for eligible participants; does not guarantee payment of the benefit. (Benefit self-funded by the Plan.)

PACIFIC HEALTH PLANS

One Union Square
600 University Street
Suite 700
Seattle, WA 98101
Provides prepaid medical, drug and vision benefits with guaranteed payment of these benefits to participants enrolled in the Pacific Health plan.

NAISMITH DENTAL GROUP

235 W. MacArthur Blvd., #700
Oakland, CA 94611
Provides prepaid dental benefits with guaranteed payment of these benefits to participants enrolled in the Naismith plan.

KAISER FOUNDATION HEALTH PLAN, INC.

Southern California Region
Walnut Center
Pasadena, CA 91188
Provides prepaid medical, drug and vision benefits to participants enrolled in Kaiser; with guaranteed payment of these benefits.

HARBOR CITY DENTAL—SAKAI

25617 Dodge Avenue
Harbor City, CA 90710
Provides prepaid dental benefits with guaranteed payments of these benefits to participants enrolled in the Harbor City plan.

DUFFY'S MYRTLEDALE

3076 Myrtle Road
Calistoga, CA 94515
Administers the substance abuse benefits; does not guarantee payment of the benefit.
(Benefit self-funded by the Plan.)

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.

KAISER FOUNDATION HEALTH PLAN OF THE NW

Kaiser Permanente Building
500 NE Multnomah Street
Suite 100
Portland, OR 97232-2099
Provides prepaid medical, drug and vision benefits to participants enrolled in Kaiser, with guaranteed payments 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.

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 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 two years:

1. Complete eye examination once by an optometrist (O.D.) or an ophthalmologist (M.D.);
2. Lenses; and
3. Frames.
4. The Plan will pay the reasonable and customary charges for special lenses, such as contact lens, if prescribed by an ophthalmologist's or Physician's written order that such special lenses are necessary to correct extreme visual acuity problems that cannot be corrected with ordinary spectacle lenses. Approval for such lenses must be obtained from the Plan Office prior to any purchase being made.

No payment or allowance will be made for:

1. More than one eye examination or pair of glasses in a two-year period;
2. Contact lenses for cosmetic purposes, nor will any allowance be made to apply towards the purchase of contact lenses;
3. Tint or photogrey lenses, unless required for safety or navigational purposes;
4. Expenses incurred by Dependents.

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 complements and coordinates with state disability programs.

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 medical plan or prepaid dental plan;

   b. The prepayment 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 plans if prescribed by a licensed Physician or Dentist.

ALCOHOL/SUBSTANCE ABUSE REHABILITATION BENEFITS

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 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 Health Management Center)

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 $5,000, 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 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 determine the disability.

TRAINING BENEFITS

The Plan provides a grant to the Andrew Furuseth School of Seamanship located at 450 Harrison Street, San Francisco, California allowing participants the ability to achieve skills that provide employers with trained personnel. The school assists participants in obtaining endorsements and maintaining regulatory compliance. Funding is provided in accordance with the collective bargaining agreement from contributions to the SUP Welfare Plan Training Fund.

ELIGIBILITY

To be eligible for training benefits, you must be eligible for the USPH Replacement Program.

LOSS OF ELIGIBILITY

When you are no longer eligible for the USPH Replacement Program or you fail to reimburse the Plan for pre-paid courses that you have not completed, your eligibility for Training Benefits will terminate.

APPROVED COURSES

The AF School has arrangements with various educational facilities that offer approved courses you elect or are required to complete. To attend these facilities, you may contact the AF School for enrollment or you may elect to make your own arrangements with another facility that provides approved courses.

Approved courses include:

- Life Boatman
- Able Body Seaman
- Radar Observer
- Tankerman
- Boat Operator (SF Bar Pilots)
- QMED
- Reefer Certification
- LSMR Training (Military Sealift Command)
- STCW Certification

TUITION

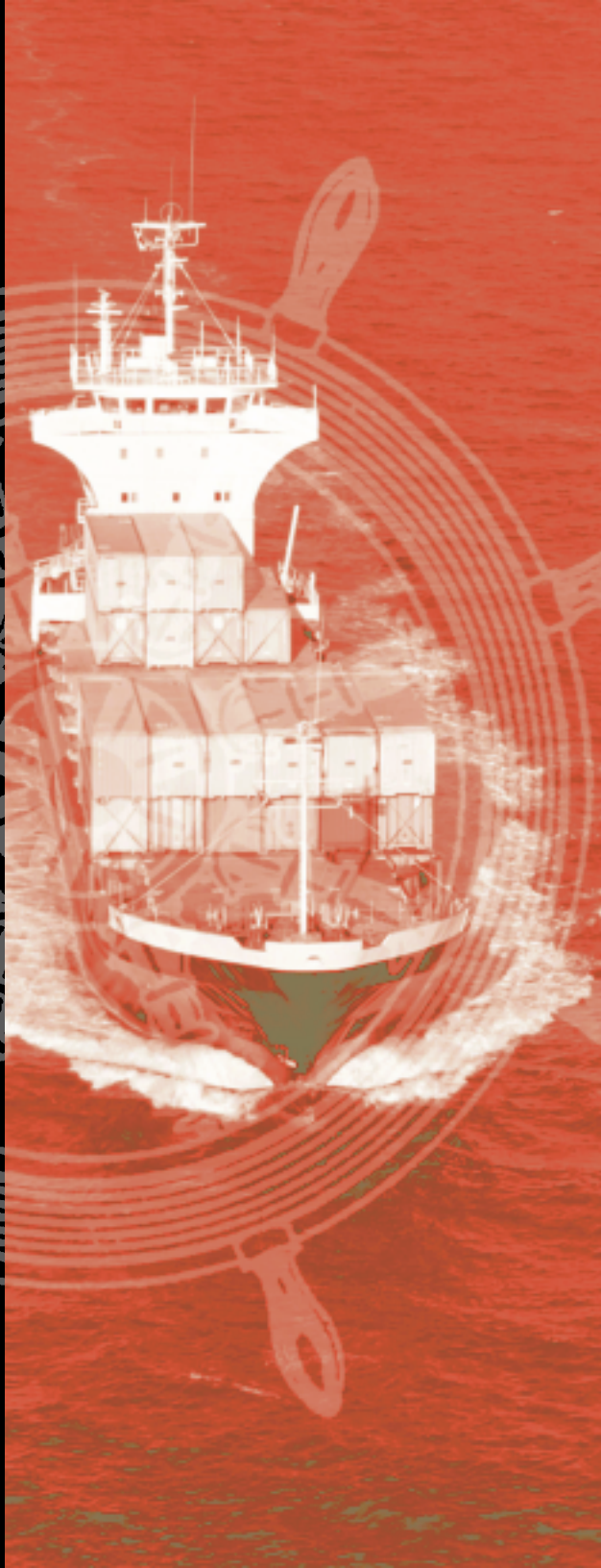
Tuition is reimbursed by the Plan for approved courses upon submitting a certificate of completion. If you fail to complete a course and tuition has been prepaid by the Plan, except in cases of hardship, you must make arrangements to reimburse the Plan before becoming eligible for future training benefits.

Upon approval, the Plan provides lodging and subsistence for attendance at courses that are required to satisfy regulatory standards and governmental agencies (STCW & LSMR Training).

Contact the AF School or the SUP Welfare Plan Office for complete information on eligibility, approved courses and schools, enrollment information, Training Record Book, tuition, lodging and subsistence policies.

AF School of Seamanship
Jack Mannering, Instructor
450 Harrison Street
San Francisco, CA 94105
Tel: 415-546-1537
Fax: 415-546-7923
Email: jacksworld@msn.com

ACTIVE EMPLOYEES' DEPENDENT BENEFITS



BENEFITS FOR DEPENDENTS OF ELIGIBLE EMPLOYEES

SELECTION OF MEDICAL AND DENTAL PLANS

Eligible Employees may elect to cover their Dependents under either the Direct Payment Plans or one of the Prepaid Medical (Health Maintenance Organization Service) and Dental Plans. Dependents residing outside of the United States or the Prepaid Plan service areas can only be covered under the Direct Payment Plan.

Each Employee will be permitted to make a change in his choice of Medical Benefit Plan coverage. However, following enrollment in any Health Maintenance Organization Service Plan or the Direct Payment Plan, such change of coverage to another Plan will not be allowed until a period of at least 12 consecutive months has elapsed, except when the Employee's Dependents have moved out of the service area of the Health Maintenance Organization Service Plan in which they are enrolled. Such change must be made in writing to the Plan Administrator in San Francisco and the enrollment card must be completed and included in such request.

In any event, while enrolled in a Health Maintenance Organization Service Plan under this Medical Benefits Plan, no individual will be eligible for any payment of benefits under the Direct Payment Plan.

All medical 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.

HEALTH MAINTENANCE ORGANIZATION SERVICE PLAN MEDICAL BENEFITS

Eligible Employees may elect for their Dependents the benefits provided by the contracts between the Plan and the Kaiser Foundation Health Plans in Northern or Southern California, Oregon and Hawaii, or the Group Health Cooperative of Puget Sound, HIP of Greater New York, Health Net of California, Blue Cross/Blue Shield of Louisiana and Pacific Health Plans in Seattle.

See pages 32-34 for the Directory of Contracted Providers.

DIRECT PAYMENT PLAN: BASIC MEDICAL BENEFITS

Hospital Benefits

The following Hospital Benefits will be paid for eligible Dependents subject to the Limitations and Exclusions beginning on page 45.

1. ROOM AND BOARD BENEFITS

Charges for daily Room and Board are payable for each day of confinement not to exceed the maximum number of Hospital Benefit days and the daily maximum rate as stated in the Summary of Benefits on page 16 for all such confinements during any one continuous period of disability.

2. HOSPITAL SERVICE BENEFITS

Hospital charges are payable for supplies and services other than Room and Board in an amount not exceeding the Hospital Service Benefit specified in the Summary of Benefits on Page 16 and incurred during that period of confinement for which benefits are payable under Room and Board Benefits.

If necessary ambulance transportation to and from a Hospital is furnished to an eligible Dependent on account of his confinement as a registered bed patient for which any Hospital benefit is payable, the Plan will pay the expenses incurred for such transportation but not to exceed the maximum amount specified in the Summary of Benefits on page 16.

No payment will be made under this benefit for expenses incurred on account of pregnancy of a female Dependent child except for involuntary complications of pregnancy.

3. LIMITATIONS AND EXCLUSIONS

a. Successive periods of Hospital confinement are considered as having occurred during one continuous period of disability unless the confinements are separated by a period of at least 90 days or unless the subsequent confinement is due to an injury or sickness entirely unrelated to the causes of the previous confinement.

b. No benefits are payable with respect to any Hospital admission primarily for diagnostic studies or tests.

c. No benefit is payable with respect to any Hospital admission of a female dependent child on account of pregnancy, childbirth, miscarriage, or abortion except for involuntary complications of pregnancy.

d. No benefit will be payable under this Hospital section for newborn nursery care unless related to injury or illness.

e. No Hospital Service Benefit will be payable unless the Hospital makes a charge for room and board, except that for Hospital Service Benefits no such room and board charge is required if the Hospital charges incurred are for service in connection with a surgical operation, or are for emergency care as a result of a non-occupational accidental bodily injury rendered within 18 hours of the time of the accident.

4. EXTENDED BENEFIT

If an eligible Dependent's coverage is terminated and if such Dependent, at the date on which his coverage ceased, is Hospital confined, the Plan will pay the benefits provided herein, subject to the same conditions and limitations as would apply if coverage were still in force.

Surgical Benefits

Upon receipt by the Plan Office of due proof that an eligible Dependent has undergone any surgical procedure performed by a licensed Physician, the Plan will pay the following benefits subject to all conditions, limitations, and exclusions set forth herein.

1. LIMITATIONS

a. With respect to each surgical procedure the maximum benefit is determined by the Relative Value units specified in the Surgical Schedule of the California Medical Association 1964 Relative Value Studies multiplied by the Conversion Factor of $15.00, up to the maximum described in item b below.

b. With respect to all surgical procedures due to the same or related causes performed during one period of disability, the maximum benefit payable is $3,000.

c. For surgical procedures not listed in the Surgical Schedule of the California Medical Association 1964 Relative Value Studies, the amount of benefit to be provided for such surgical procedures will be determined on the basis of the most nearly comparable procedure.

d. For the purpose of determining when maximum benefits have been paid or become payable for one period of disability in connection with separate surgical procedures due to the same or related causes, successive surgical procedures due to the same or related causes are considered as having been performed during the same period of disability unless the successive surgical procedures are separated by at least 90 days or unless the later procedure is due to a sickness or injury entirely unrelated to the causes of the earlier procedure.

2. EXCLUSIONS

a. No benefits will be payable under this section for charges incurred in connection with any surgery for cosmetic purposes. Cosmetic surgery is defined as surgery to change the shape or structure of, or otherwise alter a portion of the body, performed solely or primarily for the purpose of improving appearances and not as a result of a disease or condition which, in accordance with accepted medical practice, requires surgical intervention to cure, alleviate pain, or restore function. Restorative surgery performed during or following mutilative surgery which was required as a result of illness or injury is not considered cosmetic.

b. No benefit will be payable with respect to any surgical procedure for a female Dependent child on account of pregnancy, childbirth, miscarriage, or abortion except for involuntary complications of pregnancy. Involuntary complications of pregnancy will include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy and toxemia.

3. EXTENDED BENEFIT

If a Dependent's coverage is terminated, and if such Dependent at the date on which his coverage ceased will be Hospital confined, the Plan will pay the benefits provided herein, subject to the same conditions and limitations as would apply if coverage were still in force.

Physician Visit Benefits

The Plan will pay, for an eligible Dependent who has visited or received a visit from a Physician for medical treatment, in the hospital, physician's office or at home, a benefit in an amount equal to the expenses incurred, but not exceeding the maximum amount for each visit or the maximum amounts per calendar year or per hospital confinement as specified in the Summary of Benefits on page 16.

1. EXCLUSIONS

a. No benefits will be paid for more than one visit per day.

b. No benefits will be paid for the first visit due to sickness.

c. No benefits will be payable under this Physician Visit benefit for visits for treatment in connection with any surgical operation or procedure for post-operative care, unless such visits are by a Physician other than the surgeon or surgeons.

d. No benefit will be payable under this Physician Visit benefit section for visits related to pregnancy of a female Dependent child except for involuntary complications of pregnancy.

e. No benefits will be payable for well-baby care.

2. EXTENDED BENEFITS

If a Dependent's coverage is terminated, and if such Dependent, at the date on which his coverage ceased is Hospital confined, the Plan will pay the in-Hospital Doctor visits benefit provided herein, subject to the same conditions and limitations as would apply if coverage were still in force.

Diagnostic X-ray and Laboratory Benefits

Expenses for x-rays or laboratory examination for diagnosis of an illness or injury, provided while not Hospital confined, will be payable by the Plan in an amount equal to the actual expenses incurred, but not to exceed the maximum amounts specified in the Summary of Benefits on page 16.

Physical Examination Benefit

An eligible Dependent may receive an annual routine physical examination at the SIU-PD Seafarers Medical Center. As an alternative, the Plan will pay up to $75 per calendar year for a routine physical examination received from any licensed Physician, including related laboratory and x-ray charges.

Supplemental Accident Benefit

If a Dependent is injured due to a non-occupational accident while eligible under this Plan, the Plan will pay up to $300 per accident to help pay for the Hospital, medical or surgical expenses incurred for treatment of the accidental injury. Covered expenses must be incurred within 90 days of the date of the accident. The Supplemental Accident Benefit is paid in addition to other Basic Benefits payable by the Plan, not to exceed the total Usual, Customary and Reasonable charges incurred.

Exclusions under Basic Benefits

The following exclusions are applicable to all Basic Benefits:

1. Charges incurred for any individual enrolled in a Health Maintenance Organization Service Plan;
2. Charges incurred in connection with injuries sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit, or sickness for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law;

3. Charges in connection with any confinement or medical treatment in a Hospital operated by a state or government or any agency thereof, or charges by any governmental agency that would not require payment if there were no Plan;

4. Charges incurred in connection with any Hospital confinement or medical treatment or surgery rendered prior to the date the individual became covered under this Plan;

5. Hospital confinement or medical treatment not recommended or approved by a duly Licensed Physician;

6. Charges incurred for Hospital confinement or medical treatment of any bodily injury or sickness caused or contributed to by war or any act of international armed conflict, or conflict involving armed forces of any international authority;

7. Charges incurred in connection with any Dental treatment, defined as the care of teeth, gums and dependent tissues, unless such treatment is necessary for repair or alleviation of damage to natural teeth resulting from a non-occupational accidental injury occurring while the individual is covered under this Plan;

8. Charges incurred for eyeglasses and hearing aids or examinations for such prescription or fitting;

9. Charges incurred for psychiatric examinations, treatment or confinement while confined in any psychiatric institution;

10. Charges resulting from attempts at suicide or other intentionally self-inflicted injuries;

11. Charges for treatment by a Chiropractor unless such treatment is recommended or approved by a duly Licensed Physician;

12. Charges incurred for the administration of blood or blood plasma, including the cost of unreplaced blood or blood plasma, except as stated under Covered Expenses under Major Medical on page 53;

13. Charges incurred in connection with any treatment or surgery for cosmetic purposes only, except for repair or damage caused by non-occupational accidental bodily injury while eligible under the Plan. Cosmetic surgery is defined as surgery to change the shape or structure of, or otherwise alter a portion of the body, performed solely or primarily for the purpose of improving appearance and not as a result of a disease or condition which, in accordance with acceptable medical practice, requires surgical intervention to cure, alleviate pain, or restore function. Restorative surgery performed during or following mutilative surgery which was required as a result of illness or injury will not be considered cosmetic;

14. Charges incurred for acupuncture treatment unless such treatment is prescribed by a duly Licensed Physician;

15. Charges incurred in connection with administration of any injections for desensitizing any allergy;

16. Charges incurred for treatment of alcoholism administered by, or while confined in any special alcoholic treatment facility except where such facility is an integral part of an acute care Hospital, as defined by this Plan;

17. Charges for pregnancy of a female Dependent child except for involuntary complications of pregnancy;

18. Charges for investigational or experimental surgery, as defined on page 82;

19. Charges for transportation or travel other than local use of ambulance service;

20. Charges for custodial care.

MAJOR MEDICAL BENEFITS

The Deductible

In order to be entitled to receive benefits under this Major Medical Plan, each Dependent must first satisfy the $100 calendar year deductible. However:

1. All other medical benefits specified previously will apply toward the deductible, to the extent they have not been paid by Basic Benefits;

2. Any allowable expense incurred during the last three months of a calendar year which are applied against a covered individual's deductible amount will also reduce his or her deductible amount for the next calendar year;

3. The term "calendar year" means the period of 12 consecutive months commencing on January 1, of each year.

Maximum Amount

1. The maximum amount of benefits payable under this Major Medical provision applies separately to each person.

2. In no event will the aggregate amount of benefits payable exceed the maximum amount specified in the Summary of Benefits on page 16, subject to the following limitations:

   a. The maximum applies separately to each covered Dependent;

   b. A break in coverage will not constitute renewal of the lifetime maximum.

3. If evidence of good health satisfactory to the Plan is submitted to the Plan, at no expense to the Plan, with respect to any person for whom benefits of at least $1,000 have been paid, such person will again be entitled to the full maximum amount of benefits as if no Major Medical benefits had been received under the Plan.

Evidence of good health may be established by a written statement from the attending Physician or such other evidence as deemed satisfactory by the Board of Trustees.

Coinsurance

Covered medical expenses incurred by a Dependent, while eligible under this Direct Payment Plan, who has satisfied his Deductible will be paid by the Plan up to the maximum amount shown in the Summary of Benefits in the amount determined as follows:

1. 80% of the Usual, Customary and Reasonable charges for covered expenses except:

   a. There will first be deducted from the amount of incurred expense the individual's deductible amount, applicable for the calendar year in which such covered expenses are incurred, plus any Basic Benefits provided by the Plan.

   b. Payment for covered expenses incurred for and in connection with outpatient treatment of mental illness or nervous disorders is limited to a daily amount equal to the lesser of $16 or the Physician's Usual, Customary and Reasonable charge for one session and will be further limited to 50 sessions per calendar year.

An expense or charge will be deemed to be incurred on the date on which the service or supply is performed or obtained.

Payment of any benefits will be subject to all other conditions and limitations listed on page 53.

Covered Expenses

Subject to the excluded expense provision, the term "Covered Expenses" means only the following charges made for services and supplies if authorized by a legally qualified Physician as essential for the Medically Necessary treatment of an illness or injury, limited to the lesser of the actual charge or the Usual, Customary and Reasonable charge for such service or supplies:

1. Charges for Hospital room and board, services and supplies; however:

   a. The amount of daily room and board charge considered as covered expense will not exceed the Hospital's most common charge for its standard semi-private room;

   b. For each day in which the Dependent occupies accommodations in an Intensive Care Unit, the amount of daily room and board charge considered as covered expense will not exceed an amount equal to twice the Hospital's most common charge for its standard semi-private room;

2. Charges made by a Physician for professional medical or surgical services of all types;

3. Charges made for professional services by a licensed registered nurse, licensed vocational nurse, or licensed physical therapist, other than a person related by blood or marriage or a person who ordinarily resides in the Dependent's home;

4. Charges made by a radiologist or laboratory for diagnosis or treatment, or by an anesthetist, who is not an employee of the Hospital;

5. Charges made by a professional ambulance service for transporting the Dependent to and from a Hospital;

6. Charges for any of the following services and supplies to the extent they do not duplicate charges included above:

   a. Anesthetics;

   b. Drugs and medicines which can be obtained only by a Physician's prescription;

   c. Blood and blood plasma;

   d. Initial prosthetic appliances;

   e. Surgical dressings, casts and splints;

   f. Trusses, braces and crutches;

   g. Rental or purchase of durable medical equipment not to exceed the Usual, Customary and Reasonable purchase price for standard models of the equipment in question;

   h. Oxygen and rental of equipment for its administration.

7. Charges on account of a pregnancy of a female Dependent child which is extra-uterine, or requires intra-abdominal surgery or results in major toxemia such as eclampsia or hyperemesis gravidarum and further limited to such charges as listed under items 1 through 6 above.

EXCLUDED EXPENSES UNDER MAJOR MEDICAL

No Major Medical benefit will be payable for:

1. Charges which are not stated and defined in this Major Medical section as a covered expense; or

2. Charges previously excluded or limited under Basic Benefits on pages 48-50; or

3. Charges incurred by a transplant donor; or

4. Charges incurred for well baby care.

EXTENSION OF MAJOR MEDICAL BENEFITS

During Disability: If an eligible Dependent is disabled at the time his eligibility terminates, benefits are payable up to the maximum amount as if eligibility had not terminated, for covered expenses incurred on account of the sickness or injury which caused such disability until the earliest of:

1. The date on which the uninterrupted disability ceases; or
2. The end of the calendar year immediately following the calendar year in which eligibility terminated; or
3. The date the disabled person becomes covered under any other group plan for benefits of a type similar to the benefits provided for under this Plan.

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.

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

Subject to the Exclusions and Limitations listed on pages 55 and 56 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 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

In addition to Plan Limitations stated on page 56.

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.

DENTAL LIMITATIONS

Diagnostic and Prosthodontic services are subject to the following limitations:

1. Complete mouth x-rays are provided only once in a three-year period, unless special need is shown. Supplementary bitewing x-rays are provided upon request, but not more than once every six 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 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

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

Film procedures include exam and diagnosis

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

General Anesthesia—See Procedure #9220

EXTRACTIONS

Includes local anesthesia and routine post-operative visits.

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**
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	Meniscectomy 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**

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

The following procedures include all adjustments within six months following installation.

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**

DENTURES

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.

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

Adding teeth to partial denture to replace extracted natural teeth:

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**
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**

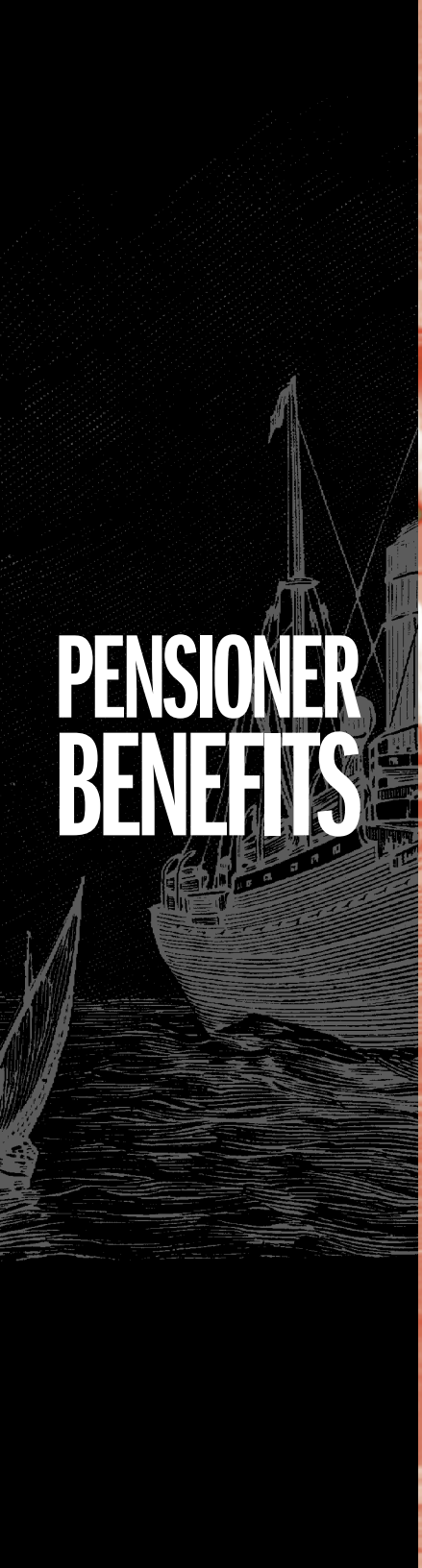
CROWNS

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 absess	**$28.80**
7971	Excision pericoronal 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.

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 in San Francisco.

HOSPITAL COMFORT BENEFIT

If a Pensioner is confined in a Hospital, 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

For a Pensioner who resides in the United States of America and incurs expenses in the United States of America for hospital, medical, surgical, dental, prescription drug or vision care and treatment, the Plan will pay a maximum benefit of up to $1,850 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 premiums up to the maximum benefit.

The Medicare 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.

Payment is charged to the benefit year based upon the date of service, not the date received 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.
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.
8. Charges incurred for maintaining Individual Coverage under any Health Maintenance Organization or insured health plan.

In addition, the following limitations and exclusions apply to Vision Care Benefits and Dental Benefits.

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, opthamologist 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 opthamologist; 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 Husband-and-Wife 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 Husband-and-Wife 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 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.

HOUSING FOR PENSIONERS AND ELIGIBLE EMPLOYEES

The Welfare Plan no longer maintains rental apartments for Pensioners or eligible Employees. The future of this benefit is currently under review by the Board of Trustees.

OTHER PLAN INFORMATION

COORDINATION OF BENEFITS

All Hospital, Medical, Surgical, and Dental benefits for all eligible Participants are subject to this provision.

If you or one of your Dependents has coverage under another plan, benefits will be coordinated with the other plan.

You and your Dependents may be entitled to benefits under this Plan as well as benefits under another Plan. In such cases, this Plan will coordinate its benefits with those provided by (a) any group coverage arranged through any Employer, Trust, Union or Employee Benefit Association, (b) any government or tax supported benefit program and (c) Medicare.

Note: When a participant who is covered by the Direct Pay Plan is also covered by a prepaid medical plan (including Health Maintenance Organizations), this Direct Pay Plan will not make reimbursement for charges made by such prepaid medical plans.

With coordination of benefits, the combined amounts of benefits payable by this Plan and the other plan(s) will not exceed 100% of the Allowable Expense incurred. Allowable Expense means any necessary, reasonable item of expense for medical care and services, at least a portion of which is covered under at least one of the plans. In no event will the benefits paid by this Plan exceed the amount which would have been paid if there were no other plans involved.

One of the two or more plans involved is the primary plan while the others are secondary plans. The primary plan pays benefits first without regard to the other plans involved. The secondary plan then pays the difference between the amount paid by the primary plan and the total Covered Expenses, not to exceed 100% of charges. If one plan has no coordination of benefits provision, it is automatically primary.

EFFECT ON BENEFITS:

In order to determine which plan will be primary and which will be secondary, the following rules will apply:

Employees and Dependents—The plan covering the Participant as an Employee will be primary and pay benefits first. The plan covering the Participant as a Dependent will be secondary and will pay benefits last.

Active/Retired or Laid-Off Employee—The plan which covers the person as an active Employee (or as the person's Dependent) pays benefits first. The plan which covers that person as a laid-off or retired Employee (or as that person's Dependent) pays benefits second.

COBRA Beneficiaries—The plan which covers the person as an Employee or Dependent of an Employee will be primary, and pay benefits first. The plan which covers the person as a COBRA Beneficiary will be secondary, and will pay benefits last.

Dependent Children of Parents NOT Separated or Divorced—The plan covering the parent whose birthday falls earliest in the calendar year, regardless of birth year, will be primary. If the birthdays of the parents fall on the same day, the plan that has covered the parent the longest will be primary. The plan covering the parent for the shorter period of time pays benefits second.

Dependent Children of Parents Separated or Divorced—The following order will apply:

1. The plan of the parent with custody pays first;
2. The plan of the spouse of the parent with custody (the stepparent) pays next; and
3. The plan of the parent without custody pays last.

If there is a court decree which would otherwise establish financial responsibility for health care expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other Plan covering the child as a dependent; the longer period of time is determined before the benefits of the plan which has covered such person the shorter period of time. A Qualified Medical Child Support Order could supercede these rules.

Longer/Shorter Length of Coverage—If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering the person for the shorter period of time pays second.

Medicare—This Plan will be primary to Medicare under the following circumstances:

1. An active Employee age 65 or older;
2. An active Employee's Dependent spouse age 65 or older;
3. The first 18 months of treatment for end-stage renal disease received by any Participant;
4. An active Employee's Dependent who is eligible for Medicare due to disability, and a disabled Employee who is eligible for Medicare, but who has coverage under the Plan as a result of current employment (for example during a trial work period).

Preferred Provider Organization—Where this Plan is coordinating benefits with another Plan which has entered into a preferred provider arrangement with a medical or Hospital provider, in no event will Allowable Expenses exceed the lesser of (a) the normal charges billed for the expense by the provider; or (b) the contractual rate for such expense under a preferred provider contract between the provider and this Plan or between the provider and the other Plan.

RIGHT TO INVOKE COORDINATION OF BENEFITS

Failure to invoke this Coordination of Benefits provision on any claim will not waive the Trustees' rights to invoke it on subsequent claims.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of enforcing or determining the applicability of the terms of this provision of the Plan or any similar provision of any other plan, the Trustees may without the consent of any person, release to, or obtain from, any insurance company, organization or person any information with respect to any person which the Trustees deemed necessary for such purposes.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Trustees will have the right, exercisable alone and in their sole discretion, to pay over to any organizations making such other payments any amounts they determine to be warranted to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Trustees will be fully discharged from liability under this Plan.

GENERAL PROVISIONS

PROOF OF CLAIM

All benefits 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.

APPEALS PROCEDURE

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 thereunder, until after the claim therefor has been submitted to and determined by the Board of Trustees.

Your claim for benefits under the Plan must be approved or denied by the Plan Office within 90 days of receipt of such claim. If determination of the claim cannot be made within that time period, you will be notified prior to the end of the original 90 days and the Plan may take up to an additional 90 days to make a decision on the claim.

If your claim for benefits is denied in whole or in part, the Plan Office will notify you of such in writing. The notice will explain in detail the reasons for denial with special reference to Plan provisions upon which the denial is based, a description of any information or material necessary to perfect the claim and why such is necessary and an explanation of the right to petition for review.

To file an appeal of a denied claim, you must file a request for review of the claim within 60 days of your receipt of the denial notice. Failure to file a request within the 60-day period will constitute a waiver of your right to appeal the denial or to take any other action within respect to it. An appeal must be in writing, should state in clear and concise terms the reason or reasons for disputing the denial, and should be accompanied by any pertinent documentary material not already furnished to the Plan.

You will be advised of the Trustee's decision in writing as soon as practical, but in no event later than 60 days after receipt of review by the Plan Office. Should there be special circumstances, the time may be extended for the processing of such request for review for a period not to exceed 120 days after receipt of a request for review. The decision on review is in writing and will include a specific reason for the decision with specific references to the pertinent provisions of the Plan on which the decision is based. The decision of the Board of Trustees, with respect to a request for reconsideration, will be final and binding upon all parties, including the claimant and any person claiming under the claimant. The provisions of this section will apply to and include any and every claim to benefits from the Plan, and any claim or right asserted under any plan adopted by the Trustees or against the Plan, regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

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 unmarried children from birth to age 19 years of age. The definition of "unmarried 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. Unmarried children under age 19 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.

   c. 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.

d. 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 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 67.

19. **Pharmacist** means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

19. **Relative** means the Employee's spouse, child, father, mother, stepmother, stepfather, stepchildren, brother, sister, halfbrother, halfsister, niece, nephew, aunt, uncle, grandmother, grandfather or grandchildren.

20. **Union** means the Sailors' Union of the Pacific.

21. **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).