

WELFARE FUND BENEFITS

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HRSA- ILA WELFARE FUND

SUMMARY PLAN DESCRIPTION

The HRSA-ILA Welfare Fund (“The Plan”) provides dental and vision benefits, disability benefits and life insurance benefits. Dental and vision claims administration are performed by Delta Dental and EyeMed Vision Care respectively. The short term disability benefits are administered by UnumProvident Insurance Company. The Plan also provides limited retiree health care benefits, as described in further detail on page 17.

UnumProvident underwrites the life insurance benefits provided by the Plan. Reliance Standard Life Insurance Company underwrites the accidental death and dismemberment insurance.

This booklet is intended only as a summary of benefits provided by the HRSA-ILA Welfare Fund. It is not a contract of insurance or a formal plan

document. It does not replace the Plan document which controls your entitlement to benefits. You have a right to see or obtain a copy of the Plan document which is called the HRSA-ILA Welfare Fund Trust Agreement. Please call the Plan Administrator’s Office at (757) 457-7090 or 1-800-899-3090 if you would like to have a copy. **In the event of conflict between the information in this booklet and the actual provisions of the Plan document, the terms of the Plan document will control.** That is, in the event of a conflict, your benefits will be determined under the Plan document rather than this Summary Plan Description. Further, **the Board of Trustees of the HRSA-ILA Welfare Fund may terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.**

Your other health care benefits are provided under the MILA National Health Care Trust Fund effective January 1, 2000. Claims administration services are provided for MILA by CIGNA Health Care; Caremark (formerly Advance PCS); and ComPsych. For a description of eligibility and benefits, refer to the Summary Plan Description forwarded to you by MILA.

ELIGIBILITY, ENROLLMENT, COVERAGE, & HIPAA

ELIGIBILITY INFORMATION

Active employee

If you are an active employee, you may qualify for coverage under the Plan if you are:

An employee covered by a Collective Bargaining Agreement between an employer-member and the ILA or affiliated local,

or

An employee of the ILA Atlantic Coast District.

and

You must work or receive credit for 1000 hours of service during the most recently ended contract year. A contract year is a period beginning on October 1 and ending on the next September 30.

For eligibility for MILA benefits, see the MILA Summary Plan Description.

Note:

Your dental, vision and weekly disability coverage will begin on the January 1 following the contract year you meet these eligibility requirements. Your coverage for Life and Accidental Death and Dismemberment Insurance will begin on October 1 following the contract year you meet the eligibility requirements.

Covering your dependents

If you are covered under the Plan, your eligible dependents can also be covered for benefits other than Short-Term Disability Benefits. Eligible dependents are:

Dependent Child

- (1) your unmarried dependent child under age 19
- or**
- (2) your unmarried dependent child age 19 through 24 who is a full time student

Your “dependent” child means a child who is dependent on you for support, who is not married, including a legally adopted child, a child placed with you for the purpose of adoption, or a stepchild.

Spouse

your spouse, if:

- (1) you are an active employee and your spouse resides with you,
- or**
- (2) you are a retiree and you have been married and residing with your spouse at least one year.

Under the MILA National Managed Health Care Trust Fund, the maximum age for dependent children eligibility for Welfare benefits offered by MILA is age 20, or age 22, if a full-time student. See MILA Summary Plan Description.

Documentation verifying that your unmarried dependent child age 19 through 24 is a full time student must be furnished to the Welfare Fund office by September 30 and January 31 of each year. If the documentation is not received by these due dates, your dependent child’s coverage will be terminated retroactive to the date that the child no longer met the requirements for eligibility. If this occurs you may be responsible for reimbursing the Welfare Fund for benefits provided to a non-eligible dependent.

Full-time student dependents are covered under the HRSA-ILA Welfare Fund until their 25th birthday. The Plan will pay the COBRA premiums for continuation of MILA coverage for student dependents until the child’s 25th birthday, or until the child is no longer a dependent and

attending school on a full-time basis, whichever comes first.

If a husband and wife are both eligible for HRSA-ILA Welfare benefits, only one of them may cover their dependents under the Plan.

Coverage for a child that is placed for adoption begins on the day that you furnish proof from the court that the child has been placed in your home within 60 days. Refer to the chart on page 19 for subsequent years of coverage for a finalized adoption.

Coverage begins when documents are submitted with eligibility, or if later than 60 days, then on the day documents are submitted.

Retiree

When you retire, you are eligible for benefits under the HRSA-ILA Welfare Plan except for short term disability and orthodontic benefits if you meet the following criteria.

You have worked or received credit for at least 1 hour in 7 consecutive contract years including or immediately preceding the year in which the eligibility determination is made,

and

10+ Years of Service

Employees with at least ten years of service must have worked or received credit for a minimum of 1000 hours* in 5 of the 7 above contract years

20+ Years of Service

Employees with at least twenty years of service must have worked or received credit for a minimum of 1000 hours* in 4 of the 7 above contract years

or

Note:

A year of service is a contract year during which you work or receive credit for at least 1000 hours in the industry. 10 years of service is the minimum required to qualify for Welfare Fund benefits as a retiree.

*** 700-hour years earned before October 1, 2004 will be counted for this requirement.**

Eligibility dates

Each person who is your eligible dependent on the day you become eligible also becomes eligible on that day. Each other person becomes eligible on the day he becomes your eligible dependent. Adopted children are deemed to be eligible on the date of placement with you for the purpose of adoption provided you furnish proof from the court within 160 days.

A dependent's coverage will begin:

- On the date he becomes eligible, if you enroll for dependents' coverage and furnish all required documentation within 60 days after the dependent becomes eligible;
- OR on the date you enroll for dependent's coverage, if you do so 61 or more days after the dependent becomes eligible. The dependent's coverage will be effective on the date the documentation for that dependent is received and accepted.

Coverage for a **newborn child** begins at birth provided you:

- apply to cover the child within 30 days after birth by furnishing a copy of the hospital certificate of birth; and
- furnish a state birth certificate within 120 days after the date of birth.

If a covered dependent child is incapable of self-support because of mental retardation, mental illness or physical incapacity that began before age 19, or age 25 if enrolled as a full-time student at the time, the coverage may be continued. You must apply for this continuation of coverage and furnish proof of the child's disability within 31 days after his eligibility would otherwise end.

Dependent Children Eligibility

This chart shows the documents required to establish and continue dependent child eligibility for Welfare Benefits. Refer to code key below chart for document.

| Child Resides With: | Relationship or Child | | |
|----------------------------|---|-------------------|--------------------------|
| | Natural or Adopted Child of Participant | Legal Custody | Stepchild of Participant |
| | Required Documents | | |
| Employee and Spouse | 1 (plus 3 if adopted) | 1, 3, 5 | 1, 5 |
| Employee Only | 1, 2, 5 | 1, 3, 5 | 1, 3, 5 |
| Spouse or Custodial Parent | 1, 2, plus 4 or 5 | 1, 3, plus 4 or 5 | No Coverage |

REQUIRED DOCUMENTS

CODE KEY

- 1** State Birth Certificate

- 2** Proof of Natural Parenthood
 - Birth Certificate which shows employee as the mother or father, or
 - Declaration of Paternity, or
 - Court Order stating that employee is the mother/father.

- 3** Court Order awarding custody or adoption

- 4** National Medical Support Notice (NMSN) or Qualified Medical Child Support Order (QMCSO)

- 5** Proof of Support must be furnished **each year**
 - Federal Income Tax Return including signature page, or
 - Copies of cancelled checks showing child support payment to custodial parent, or
 - Company payroll deduction register showing to whom payment is made (custodial parent, spouse or former spouse) with dates and amounts of support payments, or
 - Social Services documentation showing dates and amounts of support payments

Dependents of deceased employees or deceased retirees

Dependents of deceased employees or deceased retirees are eligible for all Plan benefits except for orthodontic benefits and short term disability benefits if the deceased employee or deceased retiree has met the following criteria;

Worked or received credit for at least 1 hour of service in each of the 7 consecutive contract years including or immediately preceding the contract year in which the eligibility determination is made,

and

10+ Years of Service

Deceased employee or deceased retiree must have worked or received credit for a minimum of 1000 hours* in 5 of the 7 above contract years with at least ten years of service

20+ Years of Service

Deceased employee or deceased retiree must have worked or received credit for a minimum of 1000 hours* in 4 of the 7 above contract years with at least twenty years of service

or

Note:

10 years of service is the minimum required to qualify for Welfare Fund benefits

Eligibility for the surviving spouse and all surviving dependents will end upon the remarriage or death of the surviving eligible spouse. Eligibility for dependent children, if there is no surviving eligible spouse, will end following the death of the member when the active coverage period ends.

A surviving spouse must have been married to and residing with the deceased retiree for at least one year before the retiree's death to be eligible for Plan benefits.

*** 700- hour years earned before October 1, 2004 will be counted for this requirement.**

Credits toward eligibility

You receive credit for an hour of service for each hour you are paid while employed by participating employers in the longshore industry in the Port of Hampton Roads, Virginia. Hours paid to you at the time-and-a-half or double-time rate count only as one hour. Under some circumstances, you may receive credit towards the 1000 - hour minimum eligibility level for time when you were unable to work. Credit hours may be awarded in the case of injury.

Work Related Injuries

Employees who receive temporary total or temporary partial workers' compensation benefits shall receive pro rata credit for the purposes of determining eligibility at the rate necessary to continue the employee's benefits at the same level as in the year prior to the accident.

Service in the Uniformed Services

If you are an eligible employee who qualifies under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and you serve in the uniformed services, you will receive pro rata credit for the purposes of determining eligibility at the rate necessary to continue your benefits at the same level as in the prior year.

No simultaneous Short Term Disability and Workers' Compensation credits will be applied for benefits.

NO CREDIT HOURS ARE GRANTED FOR PERMANENT TOTAL OR PERMANENT PARTIAL DISABILITY BENEFITS OR FOR LUMP SUM SETTLEMENTS.

Rainy Day Umbrella Clause

If you receive short term disability benefits as a result of a non-occupational disability and you are unable to requalify for Welfare Coverage, you may be eligible to apply for a special, one-time coverage election. This election is only available if you have ten consecutive years of service with 700 or more hours each year. You may use the election to apply for coverage if you fail to qualify during a year as a result of illness or non-occupational injuries. You will receive twenty hours per week during the period Short Term Disability benefits were paid, added to your work hours toward the 1000-hour level required for Welfare Fund benefits. The Rainy Day Umbrella Clause may be elected only a single time during your career.

WHEN COVERAGE ENDS

Participant coverage

Your coverage under the Plan ends on the earliest of the following dates:

- December 31 of the year following the contract year in which you fail to meet the eligibility requirements described in the Eligibility Information section of this booklet. Life and Accidental Death & Dismemberment Insurance ends on September 30th if you fail to earn coverage;
- The date the Plan ends or is changed so that your coverage is no longer provided.

Retiree Coverage

Coverage for a retiree will end on the date the Plan ends or is changed so that retiree benefits are no longer provided.

Retiree welfare coverage for a disabled retiree will terminate when you:

- return to work;
- fail to submit to an annual physical as required by the Board of Trustees; or
- are no longer permanently disabled (as determined by the Board of Trustees in their sole discretion).

Following a termination of a retiree's welfare coverage, the former employee

may again apply for benefits, in which event the years during which he received retiree welfare coverage shall be disregarded in reviewing the consecutive employment requirements.

Dependent coverage

Coverage for a dependent ends on the earliest of the following dates:

- The date your coverage ends;
- The date the dependent no longer meets the eligibility requirements described in the Eligibility Information section of this Summary Plan Description (for example, your spouse residing apart from you);
- The date the Plan ends or is changed so that dependent coverage is no longer provided;
- The date that adoption proceedings are discontinued provided that such proceedings do not result in finalization of the adoption; or
- At the end of the last calendar year for which benefit eligibility has been earned if there is no surviving, eligible spouse.

Your spouse's HRSA-ILA Plan coverage will end the date you and your spouse are no longer residing together.

OPTIONS FOR CONTINUING COVERAGE

When a participant's coverage ends the participant or dependent may be eligible to continue dental and vision coverage as described below under Continuation of Coverage under COBRA.

CONTINUATION OF COVERAGE UNDER COBRA

You may continue your coverage under the HRSA-ILA Plan for yourself and your covered dependents if your coverage ends due to one of the following qualifying events:

- termination of employment (unless due to gross misconduct);
- reduction of your work hours.

Your covered dependents can continue their coverage under the HRSA-ILA Plan if their coverage ends due to one of the following qualifying events:

- your death;
- your entitlement (coverage) under Medicare;
- your living apart from your spouse;
- for a dependent child, ceasing to meet the definition of an eligible dependent.

If you or your dependents elect continuation coverage, the continued coverage will be identical to the coverage you had under the Plan. However, you or your dependent will be required to pay the full cost of coverage. You must pay the full amount to us monthly. You must also pay us an additional amount for administrative expenses.

60 day notice required

You or your dependents **must notify us within 60 days** of the qualifying event, if:

- you get divorced, legally separated or are living apart from your spouse;
- a child becomes ineligible for coverage under the Plan;
- you are totally disabled at the time your employment terminates. If the Social Security Administration determines later that you were disabled at the time your employment ended, you must notify us within 60 days after the determination is made;
- a second qualifying event occurs after you become entitled to COBRA.

If you fail to notify us within 60 days of a qualifying event, you will lose your right to continuation of coverage.

We will send a notice and application for continuation coverage after we are notified. You or your dependents must return the completed application to us by the **later** of:

- 60 days after coverage under the Plan ends; or
- 60 days after we send notice of your continuation right.

You must send us the first premium payment within 45 days after you elect continuation of coverage. The first premium payment may include the amount due for coverage from the date coverage under the Welfare Fund ended.

Length of continued coverage

The length of your continuation of coverage depends upon the manner in which your regular coverage ended as well as other factors. Coverage can be continued until the earliest of the following dates:

- **Termination of employment;** coverage continues for 18 months after your employment ended or your hours were reduced, if coverage ended for that reason and you were not totally disabled.

If you or a dependent are totally disabled for Social Security purposes on the date of the qualifying event or at anytime during the first 60 days of continuation of coverage, the 18 month period may be extended to 29 months. In this situation, your cost for continuing your coverage during months 19-29 will equal 150% of the full cost of the coverage.

- **Dependent coverage;** for a dependent, the date 36 months after your death, divorce, legal separation, living apart from your spouse or a child's loss of eligibility, if coverage ended for that reason.
- **Termination of the Plan;** all continuation coverage ends the date we stop providing Plan benefits to employees.
- **Failure to make premium payments;** continuation coverage ends the date you or your dependents fail to make the required payment for coverage.

- **Coverage under another plan;** continuation coverage ends the date you or your dependents become covered under another group health plan that does not have a pre-existing conditions limitation applicable to the individual continuing coverage.
- **Remarriage of ex-spouse;** continuation coverage ends for a spouse on the date he or she remarries and becomes covered under another group health plan that does not have a pre-existing conditions limitation applicable to him or her.
- **Medicare;** continuation coverage ends the date you or your dependents become covered under Medicare.

SUBROGATION AND REIMBURSEMENT

If the Welfare Fund pays dental, vision, or short term disability payments for a participant or any covered dependent, the Welfare Fund will be subrogated to that individual's rights of recovery against a third party.

In addition, the Welfare Fund shall have a claim or lien against any monies recovered as a result of suit, judgment, settlement or otherwise against the third party in the amount of the benefits paid. The Fund may seek reimbursement from the Participant, the third party or the third party's insurance carrier.

Examples of instances where the Welfare Fund has subrogation and/or reimbursement rights include automobile accidents and workers' compensation claim settlements.

You must notify the Fund in writing of whatever benefits are paid by the Welfare Fund that arise out of any injury or illness that provides or may provide the Welfare Fund with subrogation and reimbursement rights. If we request you to do so, you must complete any documents or forms we need in order to help us attain reimbursement. Failure to provide necessary information or to reimburse the Welfare Fund within seven days after recovery of any sum may disqualify you or your family from future benefits from the Fund. Any unpaid balances will accrue interest at the current rate approved by the Board of Trustees.

Fund subrogation and reimbursement rights help us hold down the Fund's costs for providing benefits and helps ensure that we may continue to provide health care and short term disability benefits for you and the other Participants.

IF YOU HAVE OTHER DENTAL AND VISION INSURANCE

Coordination of Benefits

In cases where employees or their family members are covered by more than one group health care program, Coordination of Benefits (COB) saves health care dollars by preventing duplicate payments for the same services. Most group health care programs have a COB provision.

How COB works

When you have other coverage, and all your benefits are added together, they cannot be less than what would have been paid by this program if the other coverage did not exist. And, they cannot be more than the value of covered services.

Primary vs. secondary coverage

If you are eligible for benefits through two or more programs, the program that pays benefits first is considered “primary” and the other is called the “secondary” program.

- A program without a coordination of benefits provision will be primary;
- When a married couple has coverage through their employers, the program that covers the individual employee is primary, and the program that covers the employee’s spouse is considered secondary;

- For dependent children, the program of the parent whose birth date falls earlier in the year will be primary. For example, if your birthday is April 2 and your spouse’s birthday is July 14, your program will be primary, regardless of the year in which you were born.

Custody Rule

The Custody Rule will be used when the parents are divorced or legally separated.

If the parent with custody has not remarried:

- The parent with custody shall provide primary benefits to the dependent children;
- The parent without custody shall provide secondary benefits to the dependent children.

If the parent with custody has remarried:

- The parent with custody shall provide primary benefits to the dependent children;
- The step-parent with custody shall provide secondary benefits to the dependent children;
- The parent without custody shall provide any balance of benefits to the dependents.

If there is a divorce decree which fixes financial responsibility for the health care of the dependent children, then the decree will override the Custody Rule.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A QMCSO is a court or administrative order that provides for child support or health care coverage for an Alternate Recipient of a plan participant. The term “Alternate Recipient” means any child of a plan participant who is recognized under a medical child support order as having a right to enrollment under a group health plan. Your Plan will honor a QMCSO if it meets the following requirements.

1. The order is a National Medical Support Notice and the name and address of the child and participant are correct and the child’s age falls within that of an eligible dependent under the plan; or
2. The order is not a National Medical Support Notice, but it meets the following requirements:
 - create, or recognize the existence of the Alternate Recipient’s right to, or assign to such Alternate Recipient the right to, receive benefits for which the plan participant is eligible under the Plan;
 - clearly specify the plan participant’s name and last known mailing address and the name and mailing address of each Alternate Recipient covered by the court order;
 - specify a reasonable description of the type of coverage to be provided by the Plan to each child or the manner in which the type of coverage is to be determined;
 - specify each plan to which the court order applies and the period to which it applies;
 - provide that the Alternate Recipient is a child of a plan participant who has a right to enrollment under a group health plan in which the plan

participant is enrolled;

- identify the state domestic relations or community property law under which the order is issued and relate to group health medical benefits under the group health plan.

The court order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan.

When the Plan Administrator receives a National Medical Support Order, he will follow the procedures in that notice and respond appropriately to the child support agency that issued the notice.

When a Plan Administrator receives a Medical Child Support Order that is not a National Medical Support Notice, the following steps must be taken:

1. Both the participant and each Alternate Recipient will be notified of the Plan’s receipt of the order;
2. An explanation of the plan’s procedures for determining whether the court order is a QMCSO will be furnished to both the plan participant and each Alternate Recipient;
3. The Plan Administrator will determine if the order is qualified;
4. The participant and each Alternate Recipient will be notified of the Plan Administrator’s decision.

The Plan Administrator has the sole discretion for determining whether the court order satisfies the conditions of a QMCSO. If it does, the child is an Alternate Recipient and is considered a beneficiary under the Plan for purposes of ERISA. The child is also considered a participant under the Plan for reporting and disclosure purposes of ERISA.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment;
- means of communication among the many health professionals who contribute to your care;
- legal document describing the care you received;
- means by which you or a third party payer can verify that services billed were actually provided;
- a tool in educating health professionals;
- a source of data for medical research;
- a source of information for public health officials charged with improving the health of the nation; and
- a source of data for facility planning and marketing.

Understanding what is in your record and how your health information is used: helps you to ensure its accuracy; better understand who, what, when, where and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. The new HIPAA privacy rules establish restrictions on the use and disclosure of your health information. The HRSA-ILA Welfare Fund (the "Fund") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of: (1) making or obtaining payment for your care and (2) conducting health care operations. The Fund has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

(1) To Make or Obtain Payment

The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

(2) To Conduct Health Care Operations

The Fund may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants. Health care operations includes such activities as:

- Business management and general administrative activities of the Fund, including customer service and resolution of internal grievances.
- For Treatment Alternatives*
- The Fund may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- For Distribution of Health-Related Benefits and Services*
- The Fund may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.
- For Disclosure to the Board of Trustees of the HRSA-ILA Funds*
- The Fund may disclose your health information to the Board of Trustees for plan administration functions performed by the Board of Trustees on behalf of the Fund. Such administrative functions include:
- Quality assessment and improvement activities;
 - Activities designed to improve health or reduce health care costs;
 - Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits;
 - Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs;
 - Business planning and development including cost management and planning related analysis;
 - review of disability pension applications;
 - review of workers' compensation settlements;
 - processing of participant appeals for covered benefits.
- In addition, the Fund may provide summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from health insurers or modify, amend or terminate the plan. The Fund also may disclose to the Board of Trustees information on whether you are participating in the health plan.

When Legally Required

The Fund will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities

The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings

As permitted or required by state law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Fund makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes

As permitted or required by state law, the Fund may disclose your health information

to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety

The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions

In certain circumstances, federal regulations require the Fund to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Workers' Compensation

The Fund may release your health information to the extent necessary to comply with laws related to workers' compensation, short term disability, or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Fund will not disclose your health information other than with your written authorization. If you authorize the Fund to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Fund maintains:

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request. If you wish to make a request for restrictions, please contact the designated "Contact Person" (see contact information on page 32).

Right to Receive Confidential Communications

You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your

health information could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Contact Person. The Fund will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Contact Person. If you request a copy of your health information, the Fund may charge a reasonable fee for any copying, assembling costs and postage associated with your request.

Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing to the Contact Person. The Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to

inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

Right to an Accounting

You have the right to request a list of certain disclosures of your health information that the Fund is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Contact Person. The request should specify the time period for which you are requesting the information, but may not start earlier than **April 14, 2003**. Accounting requests may not be made for periods of time going back more than six (6) years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Contact Person.

DUTIES OF THE FUND

The Fund is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to the Contact Person. The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Fund has designated Gene Griffin as its Contact Person for all issues regarding patient privacy and your privacy rights. You may contact this person at HRSA-ILA Funds, 1355 International Terminal Blvd., Norfolk, VA 23505-1458, (757) 457-7090, Fax (757) 423-1205.

As of January 1, 2006, dental care is provided for eligible employees and dependents under the Delta Dental PPO program administered by Delta Dental of Virginia. The customer service number is 1-800-237-6060.

HOW THE DENTAL PROGRAM WORKS

Dental benefits are paid differently than other benefits under your program. Here are the key differences:

- There is a separate calendar year dental deductible of \$25 per individual for primary care, prosthetic and complex restorative care, and dentures;
- All dental procedures and supplies are divided into categories. Each category is reimbursed at a different percentage, as shown in the table on page 35;
- The program will pay up to \$1,500 a year for diagnostic & preventive care, basic dental care, prosthetic & complex restorative care, and dentures for each covered person;
- Your program pays 85% of the plan allowance up to \$2,000 for covered orthodontic care during a covered person's lifetime. Retirees and their dependents are not eligible for this benefit.

What you pay

You pay a percentage of covered dental expenses and the program pays a percentage, up to the plan allowance. Using a participating Delta Dental PPO or Premier Dentist will save you money. A non-participating provider may balance bill you for their full cost.

| FOR THIS TYPE OF SERVICE: | YOU PAY: | THE PROGRAM PAYS: | EXAMPLES: |
|---|------------|---|--|
| Diagnostic and preventive care | None | 100% of PA* | Checkups, Cleaning, X-rays |
| Basic dental care | 15% of PA* | 85% of PA* | Fillings, Extractions Repair of false teeth |
| Prosthetic and complex restorative care | 15% of PA* | 85% of PA* | Crowns |
| Dentures | 15% of PA* | 85% of PA* | Full or partial dentures, Denture repairs |
| Orthodontic care | 15% of PA* | 85% of PA* up to \$2,000 lifetime maximum (Not available to retirees and their dependents) | Orthodontic appliances, X-rays (Not available to retirees and their dependents) |

*PA = Plan Allowance

Carry Your Dental ID Card

Your Delta Dental of Virginia ID card identifies you as a member and contains important dental care information. When you show your ID card to your dentist, they will file your claims for you in most cases. Carrying your card at all times will ensure you always have this coverage information with you when you need it.

Treatment By Non-Contracting Dentists

You may select a dentist of your choice, however, this is a PPO program. This

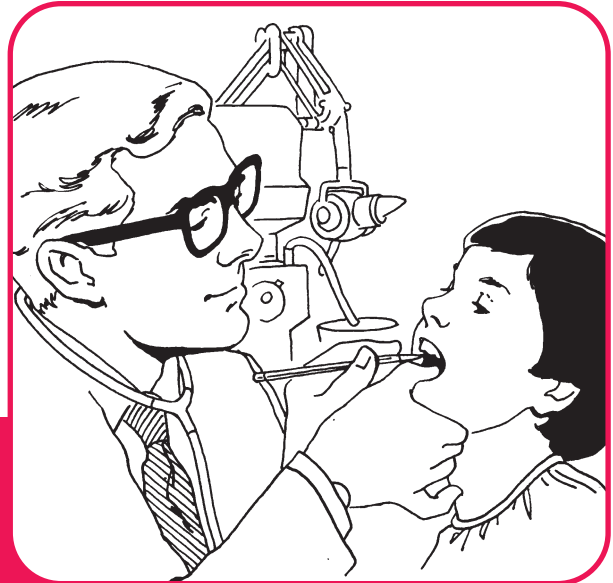
means that you will receive the highest level of benefits available in the group's program by choosing a Delta Dental PPO or Delta Dental Premier dentist. However, your out-of-pocket costs will usually be lower if you use a Delta Dental PPO dentist. Participating dentist's have agreed to accept Delta Dental's plan allowance as payment in full for covered benefits. This means that you pay the deductibles and co-insurances (if any) and the difference between the non-participating dentists' charges and the non-participating dentist allowance.

Choosing A Contracting Dentist

There are three ways you can find out if a dentist is in the network:

- Call Delta Dental at 800-237-6060;
- Visit Delta Dental's website at www.deltadentalva.com and select "Dentist Search", then select Delta Dental (PPO) or Delta Dental Premier;
- Check with your dentist, giving your name, the HRSA-ILA group number shown on your dental ID card (000700033), and tell them you are a participant with Delta Dental;

- Before a course of treatment, be sure to check with your dentist to make sure he or she still participates in Delta's network.



PREDETERMINATION OF BENEFITS

Delta Dental reviews some claims in advance. If dental services for a single procedure or series of related procedures cost more than \$250 your dentist may submit a predetermination plan prior to services being provided. Delta Dental will notify you and the dentist whether the dental services described are covered benefits and how much Delta Dental will pay. With this information, your dentist can better discuss treatment options and costs with you. However, a predetermination is not a guarantee of payment if, for example, new information is submitted with the claim indicating that a less costly method would be appropriate.

DIAGNOSTIC AND PREVENTIVE CARE

Your benefits provide coverage for “diagnostic” care so your dentist can find out what may be wrong if you have a problem. Your program also covers “preventive” dental care to prevent cavities and serious dental problems from happening.

Since this type of care can help prevent more expensive dental work, you do not have to pay a deductible for Diagnostic and Preventive Care.

Your benefits provide coverage for you to see your dentist for a checkup. Diagnostic and Preventive Dental Care is paid at 100% of the plan allowance for:

- Examinations of your teeth;
- Dental x-rays * (except x-rays needed to fit braces);

- Cleaning your teeth (prophylaxis);
- Space maintainers used to keep teeth from moving into space left when primary teeth are pulled;
- Painting teeth with fluoride to help prevent cavities;
- Dental sealants on first and second permanent molars.

- * Benefits provide coverage for a full mouth x-ray series or panorex of the mouth once every 36 months. Other x-rays that are a normal part of the checkup are covered according to the limitations in the policy.

Please see the Limitations On Frequency Or Age section on page 40 for more information on your Dental Care benefits.

BASIC DENTAL CARE

After your dentist has examined your teeth, you may need additional dental work. This includes care of teeth, gums, and other primary dental care.

Basic dental care for your natural teeth

These covered basic dental care services are related to your natural teeth. Your benefits are paid at 85% of the plan allowance after the deductible for:

- Fillings: amalgam (“silver”) materials are available on all teeth; composite (tooth-colored) materials are available on anterior (“front”) six teeth only. When a tooth-colored material is used to restore a posterior (“back”) tooth, Delta will pay the plan allowance for a similar amalgam filling. You will be responsible for any amount over the plan allowance, up to the Dentist’s charge;
- Stainless steel crowns on primary teeth;
- Oral surgery, including pulling teeth (either a simple extraction or surgical removal) and anesthesia;
Note: Surgical extraction of impacted teeth is not covered under this policy if the procedure is covered as a medical benefit under any plan under which a covered person is enrolled.
- Treatment of infected nerve tissue inside a primary tooth;

- Root canal therapy for permanent teeth.

Basic dental care for your gums

These covered primary dental care services are related to the care of your gums:

- Care for cysts, tumors or abscesses in the mouth (excision, drainage or removal) and care of acute gum (periodontal) infection or sores (oral lesions);
- Several different types of dental care for the gum (periodontic services). This includes removing infected parts of the gum and replacing them with healthy tissue (gingivectomy and gingivoplasty) and an operation on the lining of the gum (mucogingivoplastic surgery).

Other basic dental care

This list includes other covered basic dental care services:

- Making the gum ridges ready for false teeth;
- An operation to remove diseased portions of bone around the teeth (osseous surgery);
- Palliative treatment for dental pain;
- Occlusal guards, splints or occlusal adjustments of teeth for temporomandibular joint dysfunction (TMJ).

PROSTHETIC AND COMPLEX RESTORATIVE CARE

If preventive and primary care services fail to save a tooth, you can use the prosthetic and complex restorative benefits for:

- Crowns that are not part of a bridge and crown buildups;
- Post and core buildups;
- Bridges.

DENTURE BENEFITS

Dentures are also covered with replacement of existing dentures limited to once each 48 month period. The following are covered services:

- Dentures (full and partial) and denture adjustments;
- Post and core buildups;
- Repair or recementing crowns, dentures and bridges;
- Relining and rebasing dentures for a better fit.

Please see the [Limitations On Frequency Or Age](#) section on page 40 for more information on your Dental Care benefits.

ORTHODONTIC CARE

Your program pays benefits for care needed to straighten teeth. The program pays for services and supplies if the problem is a handicapping malocclusion. That means it prevents normal chewing or eating. Retirees and their family members are not eligible for orthodontic care.

Coverage is provided for:

- Diagnostic records, including x-rays and study models;
- Minor treatment for tooth guidance;
- Minor treatment to control harmful habits;
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (transitional and permanent dentition);
- Post-treatment stabilization.

Orthodontic lifetime maximum

Your program pays 85% of the plan allowance up to \$2,000 for covered orthodontic care during a covered person's lifetime. You are responsible for all charges after this maximum is reached.

LIMITATIONS ON FREQUENCY OR AGE

DIAGNOSTIC AND PREVENTIVE SERVICES

You may receive two of each of the following per calendar year:

- Periodic oral evaluations;
- Dental prophylaxis, including scaling and polishing of teeth.

You may receive one of each of the following per calendar year:

- Bitewing x-rays, limited to 4 bitewings in one visit, but not within the same calendar year as a full-mouth x-ray series;
- Other evaluations (e.g., emergency or periodontal evaluations).
- Topical fluoride applications.

You may receive one complete full mouth x-ray series or a panorex every three years.

Benefits for fluoride applications and dental pit/fissure sealants are available only to covered persons under age 19.

Sealants are limited to the unrestored occlusal surface of the first and second permanent molars.

Benefits for space maintainers are available only to covered persons under age 14. Benefits for space maintainers are also limited to twice per lifetime. Recementing of appliances is limited to once per appliance.

Individual periapical films are limited to four per calendar year, but not in the same calendar year as a complete full mouth x-ray series. These limits will not apply when rendered in conjunction with emergency treatment.

Diagnostic casts are limited to one set per lifetime.

BASIC DENTAL CARE

Restorative services will not be available if performed on a tooth surface which has had a sealant application within the prior two-year period.

For all restorative services repeat treatment is a covered benefit not sooner than 24 months after initial treatment.

Pin retention is limited to once per tooth per calendar year regardless of the number of pins per tooth.

Therapeutic pulpotomy is covered on primary teeth only.

Root canal therapy is a covered benefit not sooner than two years from initial treatment.

Splints and occlusal adjustments of teeth for temporomandibular joint disorders (TMJ) are limited to once per covered person per lifetime.

Palliative treatment is limited to two treatments per calendar year.

Scaling and root planing is limited to once every two years per quadrant.

Gingivectomy, mucogingival surgery, soft tissue/osseous grafts and periodontal osseous surgery are limited to once every three years per quadrant.

Crown lengthening is limited to once per tooth per lifetime.

Periodontal scaling in the presence of gingival inflammation is limited to once per lifetime and in lieu of routine prophylaxis.

Periodontal maintenance therapy is covered only after active periodontal therapy and limited to twice per calendar year in lieu of routine prophylaxis.

The allowable charge for services rendered in a quadrant is based upon the number of teeth requiring treatment in the quadrant.

PROSTHETIC AND COMPLEX RESTORATIVE SERVICES

Permanent crowns for persons under age 12 are not a covered benefit.

Replacement of prosthetic appliances, dentures, crowns, crown buildups, post and core to support crowns, and bridges are limited to once every five-year period. There is one exception: Replacement of a bridge will be provided prior to the end of the five-year period if one or more abutment teeth are extracted.

Denture adjustments, repairs or rebasing/relining (chairside) are limited to once per appliance per calendar year.

Denture rebasing/relining at a laboratory is limited to once per appliance per three-year period.

Recementing of crowns, onlays or bridges are limited to once per crown, onlay or bridge per lifetime.

Repair of crowns and bridges is limited to once every five-year period.

Porcelain laboratory processed veneers are limited to once every five-year period in lieu of single crowns on anterior teeth.

ORTHODONTIC SERVICES

A course of treatment may not cover a period of greater than 36 months.

After completion of a course of treatment, benefits for a new course of treatment shall only be provided if it begins at least five years after the completion of the prior course of treatment.

ALTERNATE COURSE OF TREATMENT

For any Course of Treatment, benefits will be based on the procedure that is consistent with sound professional standards and which carries the lesser fee. Examples include but are not limited to the following: (1) benefits for crowns or bridges which consist of high noble metals shall be limited to the benefits which would have been payable had noble metals been used; (2) benefits for resin restorations on posterior teeth are limited to the benefits which would have been payable had amalgam restorations been used; and (3) benefits for bridges shall be limited to the benefits which would have been payable had partial dentures been used if medically appropriate. Where benefits are reduced under this paragraph, you will be responsible, in addition to Deductibles, Copayments, or Coinsurance, for the difference between the dentist's charge for the procedure and the plan allowance for the service upon which the benefits are based.

DENTAL EXCLUSIONS

This is a list of exclusions that apply to your dental program. If you want a complete list, ask your Benefits Administrator for a copy of the group policy. Your dental benefits do not cover:

- Services not listed or described in the group policy as covered benefits;
- Dental services which are covered under any other medical benefits plan under which a covered person is enrolled. Examples of such services may include dental services for an accidental injury or surgical extraction of impacted teeth;
- Any service determined to be experimental or investigative by Delta Dental in its sole discretion;
- Any service determined to be not necessary or customary for the diagnosis or treatment of your condition by Delta Dental in its sole discretion;
- Services of any type rendered in conjunction with the services of an attending provider whose services are not covered by the policy;
- Services provided by a member of the covered person's immediate family;
- Any payment or services provided or available to the covered person:
 - (1) For injuries or conditions that may be covered under workers' compensation or similar employer liability laws; also benefits or services that are available under any federal or state government program (subject to the rules and regulations of those programs) or from any charitable foundation or similar entity;
 - (2) Under the Medicare program or under any similar program authorized by state or local laws or regulations or

DENTAL EXCLUSIONS CONTINUED

any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payor after benefits under the policy have been provided. This exclusion applies whether or not the covered person waives his or her rights under these laws, amendments, programs or terms of employment. However, Delta Dental will provide payment for covered services when benefits under these programs have been exhausted.

- Services for, or related to, cosmetic surgery including routine complications of the surgery. Cosmetic surgery is a surgical service performed solely to improve a person's appearance;
- Services which are not prescribed by, performed by or upon the direction of a provider licensed to do so;
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual association, labor union, trust or similar person or group;
- Services rendered prior to the covered person's effective date;
- Services rendered after the date of termination of the covered person's coverage. There is one exception. Covered prosthetic services which are prepped or ordered before the termination date are covered if completed within 30 days following the termination date;
- Telephone consultations, charges for failure to keep a scheduled visit, charges for completing claim forms or charges for providing information in connection with a claim;
- Dental services for increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, correcting developmental malformations or for esthetic purposes;
- Services rendered for purposes other than to eliminate oral disease and/or replace covered missing teeth (mouth rehabilitation);
- Gold foil restorations;
- Guided tissue regeneration, including flap entry or re-entry and closure;
- Gingival curettage;
- Occlusal guards and athletic mouth guards;
- Inlays and recementing inlays;
- Temporary dentures, crowns or duplicate dentures;
- Oral or inhalation sedation;
- Silicate restorations;
- Bleaching of discolored teeth;
- Dental pit/fissure sealants on other than first and second permanent molars;
- Root canal therapy on other than permanent teeth;
- Pulp capping (direct or indirect);
- Fixed bridges when done in conjunction with a removable appliance in the same arch;
- Behavior management or hypnosis;

DENTAL EXCLUSIONS CONTINUED

- Acupuncture;
- Prescription drugs and therapeutic injections;
- Upgrading of working dental appliances;
- Precision attachments for dental appliances;
- Separate charges for pulp vitality tests; bases and liners under restorations;
- Sedative fillings;
- Tissue conditioning;
- Separate charges for infection control procedures and procedures to comply with OSHA requirements;
- Separate charges for routine irrigation or re-evaluation following periodontal therapy;
- Analgesics (nitrous oxide);
- Prefabricated resin crowns;
- Diagnostic photographs;
- Dietary instruction or counseling;
- Therapeutic pulpotomy on permanent teeth;
- Periodontal splinting and occlusal adjustments for periodontal purposes;
- Dental implants and associated services in conjunction with implants;
- Occlusal analysis;
- Controlled release of medicine to tooth crevicular tissues for periodontal purposes;
- Tooth desensitizing treatments;
- Separate charges for hospital visits;
- Dental care in excess of the benefit maximums of your program;
- Care by more than one dentist when you transfer from one dentist to another during the course of treatment;
- Care by more than one dentist for one dental procedure;
- Any alternate course of treatment that is more expensive than another one that is consistent with accepted professional standards;
- Amounts in excess of the plan allowance for a covered benefit;
- Inpatient or outpatient facility charges;
- Services billed under multiple dental service procedure codes which Delta Dental, in its sole discretion, determines should have been billed under a single, more comprehensive dental service procedure code. Delta Dental's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes;
- Services billed under a dental service procedure code that Delta Dental, in its sole discretion, determines should have been billed under a code that more accurately describes the dental service. Delta Dental's payment is based on its determination of the more accurate dental service code.

CLAIMS FILING

Most dentists can file claims for you directly when you show them your Delta Dental identification card. Written notice of a claim is to be made within 20 days after the occurrence or commencement of any loss covered by the dental plan. However, failure to give this notice shall not invalidate or reduce any claim if the notice is given as soon as reasonably possible. Claim forms will be furnished to you if needed within 15 days after this written notice.

Written proof of loss must be furnished within 90 days after the date of service. A proof of loss is not complete unless it is properly filed and contains all information that Delta Dental needs to process the claim. Failure to furnish the proof of loss within this time frame will not invalidate or reduce any claim if the proof of loss is given as soon as reasonably possible. However, no claim will be paid if we receive the proof of loss more than 12 months after the date of service, except in the absence of legal capacity of the covered person. All benefits payable for a claim will be payable within 60 days after the receipt of the proof of loss.

If your provider cannot file a claim for you, you must submit a claim yourself. Send Delta Dental a completed claim form along with itemized bills for covered services. Each itemized bill must contain the following:

- Name and address of the person or organization providing services or supplies;
- Name of the patient receiving services or supplies;
- Date services or supplies were provided;
- The charge for each type of service or supply;
- A description of the services received to include valid American Dental Association (ADA) codes for each service;
- A description of the patient's condition.

Additional information such as x-rays or narratives may be requested from your provider before the claim can be processed.

The completed form and itemized bills should be mailed to:

**Delta Dental of Virginia
Attn: Claims Department
4818 Starkey Road
Roanoke, VA 24018**

Payment will be made directly to the Network Dentist unless the dentist indicates that you have already paid him or her. If you go to a non-network dentist, payment may be made to the provider, to you or to anyone else responsible for paying the claim. If you file a claim for services not billed for by a dentist, payment will be made directly to you.

WHEN YOUR CLAIM IS PROCESSED

In processing your claim, your dental plan may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the “**Claims Filing**” paragraph of this section will be processed within 30 days of receipt of the claim. We may extend this period for another 15 days if we determine it to be necessary because of matters beyond our control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 30-day period. If the coverage decision involves a determination of the

appropriateness or medical necessity of services, we will make our decision within 2 working days of our receipt of the medical information needed to process the claim.

Your dental plan may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by you or your provider furnishing the additional information. You or your provider must submit the additional information to us within either 15 months of the date of service or 45 days from the date you were notified that the information is needed, whichever is later. Once your claim has been processed by your dental plan, you will receive written notification of the coverage decision. In the event of an adverse benefit determination, the written notification will include the following:

- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed; and
- a description of your dental plan’s appeal procedures and applicable time limits.

If all or part of a claim was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that your dental plan relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

COMPLAINT AND APPEAL PROCESS

In order for your dental plan to remain responsive to your needs, we've established both a complaint process and an appeal process. Should you have a problem or question about your dental plan, a Benefit Services representative will assist you. Most problems and questions can be handled in this manner. You may also file a written complaint or appeal with us. Complaints typically involve issues such as dissatisfaction about your dental plan's services, quality of care, the choice of and accessibility to your dental plan's providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by your dental plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will

receive a response within 30 calendar days of your dental plan's receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, you will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to you within an additional 30 calendar days.

Important: Written complaints or any questions concerning your dental insurance may be filed to the following address:

**Delta Dental of Virginia
Attn: Claims Department
4818 Starkey Road
Roanoke, VA 24018**

Appeal Process

Your dental plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions you find unacceptable. Types of appeals include:

- internal appeals are requests to reconsider coverage decisions of pre-service or post-service claims. Expedited appeals involve requests to reconsider coverage decisions where the application of pre-service or post-service time periods for making appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician or dentist, would subject the patient to severe pain; and

- external appeals are requests for an independent, external review of the final coverage decision made by your dental plan through its internal appeal process.

How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation of why you feel the coverage decision was incorrect. Alternatively, this information may be provided to a Benefit Services representative over the phone. This is your opportunity to provide any new information that you feel your dental plan should consider when reviewing your appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- your identification and group number (as shown on your identification card); and
- the name of the dental care professional or facility that provided the service, including the date and description of the service provided and the charge.

How your dental plan will handle your appeal

In reviewing your appeal, we will take into account all the information you submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the

Important: You may contact Delta Dental Benefit Services with your appeal or any questions concerning your dental insurance at the following:

**Delta Dental of Virginia
Attn: Claims Department
4818 Starkey Road
Roanoke, VA 24018**

Telephone: 800-237-6060

You must file your appeal within 180 days of the date you were notified of the adverse benefit determination.

correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by an actively practicing practitioner from the same or similar specialty who typically treats the dental condition or provides the procedure or treatment in question, and is not employed by or as a director of your dental plan. An actively practicing practitioner is an individual who provides direct patient care, is board certified or board eligible, and is licensed to practice in Virginia or under similar licensing laws. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

Upon receipt of your appeal, Delta Dental will send you a confirmation letter within 5 business days. We will resolve and respond in writing to your appeal within the following time frames:

- 30 days from the receipt of the request to appeal a pre-service claim;
- 60 days from the receipt of the request to appeal a post-service claim; or
- One working day from the receipt of the request to appeal, if an expedited appeal was requested by the member or the treating provider.

When our review of your appeal has been completed, you will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. You will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgement as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

QUESTIONS OFTEN ASKED ABOUT THE HRSA-ILA DENTAL PLAN

How does Delta Dental pay for covered benefits?

- Covered Benefits by Delta Dental PPO Dentists;

Our payments are based on Delta Dental PPO Allowances. Delta Dental PPO Dentists have agreed to accept Delta Dental PPO Allowances as payment in full for covered benefits. This means that you pay the deductibles and co-insurances (if any) for these services. In almost all cases, we pay Delta Dental PPO Dentists directly for covered benefits that they provide.

- Covered Benefits by Delta Dental Premier Dentists who are not Delta Dental PPO Dentists;

Our payments are based on Delta Dental Premier Allowances. Delta Dental Premier Dentists have agreed to accept Delta Dental Premier Allowances as payment in full for covered benefits. This means that you pay the deductibles and co-insurances (if any) for these services. The amount you would owe a Delta Dental Premier Dentist who is not a Delta Dental PPO Dentist is typically higher than the

amount you would owe a Delta Dental PPO Dentist for the same covered benefit. In almost all cases, we pay Delta Dental Premier Dentists directly for covered benefits that they provide.

- Covered Benefits by Non-Participating Dentists;

Our payments are based on Non-Participating Dentist Allowances. Non-Participating Dentists have not agreed to accept either Delta Dental PPO Allowances or Delta Dental Premier Allowances as payment in full for their services. This means that, in addition to what we pay, you must pay the deductibles, co-insurances (if any), and the differences between the Non-Participating Dentists' charges and the Non-Participating Dentist Allowances for covered benefits. The amount you would owe a Non-Participating Dentist is typically higher than the amount you would owe either a Delta Dental PPO Dentist or a Delta Dental Premier Dentist for the same covered benefit. Unless Virginia law requires otherwise, Delta Dental will pay you directly for any covered benefits that non-participating dentists provide.

GLOSSARY OF TERMS

The following are some important definitions of words and phrases used throughout the book.

ADVERSE BENEFIT DETERMINATION - is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by the dental plan.

PLAN ALLOWANCE (PA) - this term means Delta Dental's allowance for a specific covered service or the dentist's charge for that service, whichever is less. Delta Dental's allowance for a specific covered service is determined by Delta Dental in its sole discretion.

BENEFIT PERIOD - is the specified period of time during which covered benefits must be received in order to be eligible for payment by Delta Dental.

CALENDAR YEAR - is the period from January 1 through the following December 31.

COINSURANCE - is the percentage of the cost an employee pays for covered benefits after any applicable deductible is met. For example: if the payment percentage listed in the "Benefits Cover" column in the Schedule of Benefits is 80% of PA, your coinsurance for that service is the other 20% of PA. If a deductible or copayment also applies to the covered service, the coinsurance would be 20% of the remaining balance after the deductible or copayment is applied. Delta Dental will notify you of the amount of the coinsurance on the explanation of benefits you receive.

COMPANY - means Delta Dental of Virginia ("Delta Dental").

COPAYMENT - means a specified dollar amount of a specific covered service that must be incurred by you before Delta Dental will pay for the remaining charges for that service.

COURSE OF TREATMENT - is any number of procedures performed by a provider in a planned series of covered dental services.

COVERED CHARGES - are charges for services listed as covered in your group policy. Your benefits cover a percentage of the allowable charge for most covered services received by you or your enrolled family members.

COVERED PERSON - means you and, if you have family coverage, your dependents.

COVERED BENEFIT - is a service or supply specified in the policy for which benefits will be provided when rendered by a provider. The extent to which benefits will be provided is specified in the schedule of benefits and other sections of the policy.

DEDUCTIBLE - is a fixed dollar amount each enrolled individual must pay before receiving program benefits.

EFFECTIVE DATE - is the date on which coverage begins under this policy for you and your enrolled dependents.

ELIGIBLE DEPENDENT - is an employee's spouse/child who qualifies as a dependent under the terms of the Plan.

ELIGIBLE EMPLOYEE - is an employee who meets the requirements for eligibility contained in the Collective Bargaining Agreements.

EXCLUSIONS - means services or supplies which will not be covered under any circumstances. Exclusions are limitations on covered benefits.

EXPERIMENTAL/INVESTIGATIVE - is a service or supply which is judged to be experimental or investigative at Delta Dental's sole discretion. This includes any medical complications arising from the procedure.

GLOSSARY OF TERMS CONTINUED

MEDICALLY NECESSARY - is a standard all services must meet to be covered under your program. If Delta Dental determines that services you receive are not medically necessary, benefits will be denied. Determination of medical necessity is made at Delta Dental's sole discretion. To be considered medically necessary, a service must:

- Be required to identify or treat an illness or injury;
- Be consistent with symptoms or the diagnosis and treatment of your condition;
- Be in accordance with standards of generally accepted medical/dental practice;
- Be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, the patient's family, or his or her provider; and
- Be performed in the least costly setting.

A "**setting**" is the place where you receive treatment. A setting could be your home, your professional provider's office, a skilled nursing home or hospital inpatient room. Only your medical condition (not your financial or family situation, the distance you live away from the place of treatment or any other non-medical factor) is considered in deciding which setting is medically necessary. As a patient's medical condition changes, the need for a particular setting may change.

"**Medically necessary**" is an especially important phrase because it is the basis on which benefits for services are provided or denied. Just because the service is prescribed by a professional provider does not mean the service is medically

necessary. In an effort to make treatment convenient or to follow the wishes of the patient or the patient's family, a professional provider may suggest or permit a method of providing care that is not medically necessary. To be considered medically necessary a "valid need" for the service must be demonstrated.

NETWORK DENTIST - is a dentist who, at the time of rendering professional services to you, is listed as participating in the Delta Dental PPO or Delta Dental Premier network.

Network Dentists agree to accept Delta Dental's plan allowance as payment in full. You are only responsible for any applicable deductibles, copayments or charges for non-covered benefits. There is one exception when you receive "Alternate Treatment", as outlined on page 42.

POST-SERVICE CLAIMS - are all claims other than pre-service claims and urgent care claims. Post service claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where you request authorization in advance.

PRE-SERVICE CLAIMS - are claims for a service where the terms of the dental plan require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive authorization for a service when authorization in advance is not required, that claim will be considered a post service claim.

EyeMed is the service provider of the vision program for all eligible HRSA-ILA Welfare Fund participants and their dependents.

BASIC VISION COVERAGE

The EyeMed program covers vision needs such as eye examinations, eyeglasses, and contact lenses. Vision services frequency available once every 24 months for exam, frame, standard plastic lenses or contact lenses. **Your vision program will pay a greater benefit when you receive vision care at an EyeMed select network provider.**

WHAT IS COVERED

| VISION CARE SERVICES | MEMBER COST | OUT OF NETWORK Reimbursed up to: |
|---|--|----------------------------------|
| Eye Exam with Dilation as Necessary | \$10 Copay | \$30 |
| Frames | \$15 Copay; \$100 Allowance, 20% off balance over \$100 | \$30 |
| Standard Plastic Lenses: | | |
| Single Vision | \$10 Copay | \$25 |
| Bifocal | \$10 Copay | \$35 |
| Trifocal | \$10 Copay | \$45 |
| Standard Progressive | \$10 Copay | \$35 |
| Premium Progressive | \$10 Copay, 80% of charge less \$120 Allowance | \$35 |
| Lens Options: | | |
| UV treatment | \$15 | N/A |
| Tint (solid or gradient) | \$15 | N/A |
| Standard Plastic Scratch Coating | \$15 | N/A |
| Standard Polycarbonate | \$40 | N/A |
| Standard Anti-Reflective Coating | \$45 | N/A |
| Polarized | 20% off Retail Price | N/A |
| Other Add-Ons and Services | 20% off Retail Price | N/A |
| Contact Lenses | | |
| Standard Fit & Follow-up | \$0 Copay, Paid in full fit and two follow-up visits . | \$40 |
| Premium Fit & Follow-up | \$0 Copay, 10% off retail price, then apply \$40 allowance | \$40 |
| Conventional | \$25 Copay; \$100 Allowance, 15% off balance over \$100 | \$75 |
| Disposable | \$25 Copay; \$100 Allowance, balance over \$100 | \$75 |
| Lasik Vision Correction Lasik or PRK from U.S. Laser Network | 15% off retail price or 5% off promotional price | N/A |

EyeMed allows members to choose frames from private practice providers or optical retail providers such as LensCrafters, Pearle Vision, Sears Optical, Target Optical or JCPenney Optical. Eligible participants may apply their frame allowance to the frame of their choice and will receive 20% off the remaining balance.

You will receive a forty percent (40%) discount on additional complete pairs of eyeglasses and a 15% discount off conventional contact lenses once the funded benefit has been used.

You can determine your eligibility for services and locate an EyeMed network doctor by calling **1-866-723-0514**. Representatives of the Customer Care Center are available Monday through Saturday between 8:00 a.m. and 11:00 p.m. and Sunday between 11:00 a.m. and 8:00 p.m., Eastern Standard Time.

Member brochures including a detail of the plan design and a personalized provider directory for each subscriber is mailed to the home address of all eligible

participants along with an EyeMed ID card. ID cards are not required for a member to receive services. EyeMed distributes them as a courtesy to expedite the service process as they supply providers with all of the information needed to complete eligibility verification.

ADDITIONAL RESOURCES:

www.eyemedvisioncare.com

EyeMed's website service;

- Education information
- Provider locator
- Member benefit plan look-up and eligibility information once member register's on-line
- Download an Out-of-Network Claim Form
- Request a member ID Card
- Order replacement contact lenses to be mailed directly to your home

EXCLUSIONS

Benefits will not pay for:

- Benefits are not provided for services or materials arising from: orthoptic or vision training, subnormal vision aids and any associated supplemental testing; aniseikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures;
- Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear;
- Services provided as a result of any workers' compensation law or similar legislation; or required by any governmental agency or program, whether federal, state or subdivisions thereof;
- Plano (non-prescription) lenses and/or contact lenses; non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals; services or materials provided by any other group benefit plan providing vision care;

EXCLUSIONS *CONT'D.*

- Certain brand name vision materials in which the manufacturer imposes a no-discount policy;
- Services rendered after the date an insured person ceases to be covered under the Policy, except when vision materials ordered before coverage ended are delivered and the services rendered to the insured person are within 31 days from the date of such order;
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

SHORT TERM DISABILITY INSURANCE



PLAN OUTLINE

The HRSA-ILA Welfare Fund provides Short Term Disability Insurance to protect your income if you are unable to work due to non-occupational accident or sickness. This benefit is available to active employees and may not be received on or after the date of your retirement or the date your Employment in the Industry ends. HRSA-ILA Short Term Disability Benefits are adjudicated and paid by UnumProvident Insurance Company.

WEEKLY BENEFIT

The level of benefit you receive is based upon your prior-year work hours. If you qualify for benefits, however, you may not receive more than 2/3rd of your average weekly work wage calculated from 365 days worked prior to your accident or injury.

| CREDIT HOURS | WEEKLY BENEFIT |
|--|--------------------------------|
| 700 hours thru 999 credit hours during the prior contract year | \$175 per week |
| 1,000 hours thru 1,099 credit hours | \$250 per week |
| 1,100 hours thru 1,399 credit hours | \$375 per week |
| 1,400 hours thru 1,999 credit hours | \$525 per week |
| 2,000 hours or more | \$725 per week |
| Maximum Benefit Period | 52 weeks (as described herein) |

Once a weekly benefit begins, the benefit amount will remain the same for the remainder of your disability benefit period even if the period spans into a new year and you qualify for a greater or lesser amount. You will be paid the weekly benefit if, while covered, you become totally disabled as the result of a non-work related accidental injury or sickness.

When do Benefits Begin:

The coverage will begin on the earliest of the following dates:

- the first day of disability due to accident;
- the eighth day of disability due to sickness;
- the first day you are confined in a hospital or have outpatient surgery.

Your disability payments will be paid two weeks after each period of approved disability.

Elimination Period:

The seven days of disability due to sickness prior to the beginning of benefits.

When are you “totally disabled”?

Totally disabled means that you are:

- under the regular care of a licensed physician who is practicing within the scope of his/her license during the entire period of disability; and
- unable to perform the duties of your occupation; and
- not employed for wage or profit.

- not employed for wage or profit.

Termination of Benefits:

The benefit may continue for as long as 52 weeks. You will receive the same benefit amount during any one period of disability. In no case will the benefit begin prior to the first day you are treated by a doctor. The benefit will stop the date you cease to be totally disabled, the date you return to work, the date that you begin receiving a pension under the HRSA-ILA Pension Plan, or the date your Employment in the Industry ends (See definition on page 59). You must be under the care of a doctor during the entire period for which benefits are claimed.

You will cease to be covered on the earliest of the following dates:

- the date your employer discontinues the Plan;
- the date your Employment in the Industry ends;
- the date you begin receiving pension from the HRSA-ILA Pension Plan;
- the date you cease to be eligible;
- the date of your death.

SUCCESSIVE PERIODS OF DISABILITY

Successive periods of disability not separated by seven days of work are considered the same period unless the later disability:

- is due to an injury or sickness entirely unrelated to the cause of the earlier disability; and
- begins after you return to work.

Successive periods of disability due to injuries received in one accident are considered as one period. The Board will determine, in its sole discretion, whether multiple injuries or periods of disability are related to a single accident.

IMPORTANT NOTE: Any participant who incurs a second violation of the Industry's Drug and Alcohol policy, and is terminated from Employment in the Industry for one (1) year, shall be automatically terminated and will lose Short Term Disability Coverage as of the date of such termination.

GENERAL EXCLUSIONS

DISABILITIES NOT COVERED

Benefits will not be paid for any disabilities caused by, contributed to by, or resulting from your:

- occupational sickness or injury;
- intentionally self-inflicted injuries, while sane or insane;
- active participation in a riot;
- loss of a professional license, occupational license or certification;
- cosmetic surgery, except surgery made necessary by accidental injury incurred while covered under the Plan;
- elective surgery
- commission of a crime for which you have been convicted; or
- attempt to commit a crime.

The Plan will not cover a disability due to war, declared or undeclared, or any act of war.

The Plan will not cover a disability that occurred before you become eligible for benefits.

We will not pay a benefit for any period of disability during which you are incarcerated.

The Plan will not cover a disability due to substance abuse unless treatment is provided by the Member Assistance Program. The Member Assistance Program may be reached 24 hours per day, 7 days a week, by calling the following number: 1-877-595-5282.

You may not receive short term disability benefits during any period for which you are receiving workers' compensation benefits even if the medical conditions giving rise to the claims are completely unrelated.

CLAIMS FOR BENEFITS

UnumProvident has initiated a telephonic claim filing system to process claims and expedite disability payments.

To check on your claim status, call UnumProvident at 1-800-858-6843.

TERMS YOU SHOULD KNOW

Many terms used in this booklet have special meanings. A list of these terms and their meanings follows:

“**DISABILITY**” AND “**DISABLED**” means that because of illness or injury you cannot perform each of the material duties of your occupation, and you are not employed for wage or profit.

Furthermore, you are not considered disabled or under a disability unless you are under the regular care and treatment of a licensed physician, who is practicing within the scope of his/her license during the entire period of disability. A Substance abuse related disability is not covered unless you participate in and are following a rehabilitation or treatment plan with the Member Assistance Program.

“**DISABILITY BENEFITS**” means money that is paid as a weekly benefit when your claim for disability benefits has been approved.

“**ELIMINATION PERIOD**” means a period of consecutive days of disability for which no Short-Term Disability benefit is payable. The elimination period is shown in the Plan outline and begins on the first day of disability.

“**EMPLOYMENT IN THE INDUSTRY**” means

- employment by one or more present or former employer-members of the HRSA in the Port of Hampton Roads and vicinity under the Collective Bargaining Agreement;
- employment by the ILA in the capacity of a Union Representative;
- employment by the HRSA-ILA Trust Funds where contributions are made for employees; or
- other employment by one or more employer-members of the HRSA or the ILA for which contributions are made.

A Participant is no longer “Employed in the Industry” if he or she terminates or is terminated from employment under the Collective Bargaining Agreement.

“**GROSS WEEKLY BENEFIT**” means the disability benefit amount before any reduction for other income benefits and earnings.

“**ILLNESS**” means sickness, disease, or other medical conditions including pregnancy.

“**COMPLICATIONS OF PREGNANCY**” means that part of pregnancy during which abnormal conditions or concurrent disease significantly affect the pregnancy’s usual medical management.

A complication may exist:

- during the pregnancy;
- during the delivery; or
- after the delivery.

Complications of pregnancy does not include an elective cesarian section.

“**INJURY**” means bodily injury resulting directly from an accident and independently of all other causes. The disability resulting from the injury must begin while you are covered under the Plan.

“**MEMBER ASSISTANCE PROGRAM**” is a benefit provided by the MILA Managed Health Care Trust Fund. As of October 1, 2007, the Member Assistance Program is administered by ComPsych.

“**NET WEEKLY BENEFIT**” means the disability benefit amount after any reduction for other income benefits and earnings.

“**PHYSICIAN**” means a person (other than you, your spouse, child, brother, sister or parent, or the child, brother, sister or parent of your spouse) who is:

- Operating within the scope of his/her license; and either
- licensed to practice medicine and prescribe and administer drugs or to perform surgery; or

- legally qualified as a medical practitioner and required to be recognized, under the policy for insurance purposes, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

For purposes of treating drug or alcohol dependency, a “Licensed Clinical Social Worker” is included in the term “Physician.”

“You” AND “YOUR” means you, the employee.

GENERAL INFORMATION TO KNOW

SUBMITTING A CLAIM

You must give the claims administrator proof of claim no later than 90 days after your disability starts. If that is not possible, you must notify the claims administrator as soon as you can.

You must give the claims administrator proof of continued disability and regular treatment by a physician within two weeks of the date the claims administrator requests such proof.

PAYMENT OF CLAIMS

When the claims administrator receives satisfactory proof of claim, and your claim for disability benefits is approved, benefits payable under the Plan will be paid weekly during any period that you remain disabled under the terms of the Plan. For administrative purposes a two week payment lag has been established to mitigate overpayments to a participant who may have already returned to work while the claim application was still in the process of review.

All benefits are payable to you, however, if you are not competent, the plan administrator shall pay any benefits due to your designated beneficiary or court appointed representative.

PROOF OF A CLAIM

In order for a claim to be processed, the claims administrator must receive your application for benefits, as well as sufficient medical evidence in support of your claim. Such evidence may consist of records from your doctor, narrative reports, x-rays and any other medical records, as well as evidence that you continue to be under the appropriate care and treatment of a physician. In the absence of such proof, the claims administrator may elect to suspend benefits until such proof is received.

Your disability must be supported by current medical evidence. You must be under the continuous care of a qualified physician, with a course of treatment that is appropriate for your condition.

If your doctor cannot substantiate your disability by objective findings, you may be required to see a doctor selected by the claims administrator for an independent evaluation. Failure to cooperate with such requests may result in an interruption in benefits.

QUESTIONS OFTEN ASKED ABOUT THE HRSA-ILA SHORT TERM DISABILITY PLAN

When do disability benefits become payable?

The claims administrator approves payment of a weekly benefit after the end of the elimination period and only when you and your doctor provide proof that you:

- are disabled due to illness or injury; and
- are under appropriate treatment and care of a physician.

What conditions must be met for benefit payments to continue?

You will be paid a weekly benefit as long as you remain disabled and are under the appropriate treatment and care of a physician. You will not be paid longer than the maximum benefit period shown in the Plan outline.

The claims administrator may require that you be examined by an independent physician specialist. If you fail to comply with such a request, the result may be an interruption in or suspension of benefits. Benefits may also be suspended if the results of the independent examination determine that you are not disabled under the definition of the Plan.

You will be required to file a claim with the claims administrator in order to be considered for benefits. You will also be required to give the claims administrator periodic proof that your disability continues. Such proof will be provided at your expense.

Benefits paid for the treatment of substance abuse will continue as long as

you actively participate in a rehabilitation program under the supervision of the Member Assistance Program, and comply with any other continuing treatment requirements as determined by the Funds in its sole discretion. Failure to continue with such program will result in the immediate suspension of benefits.

How is the benefit figured?

Based upon your hours during the previous Contract Year, you will qualify for one of the weekly benefit levels shown on page 56, however, your weekly benefit will not exceed 2/3^{rds} of your basic weekly earnings during the 365 days of employment prior to your injury or illness. Benefits payable for less than one week will be paid to you at the rate of 1/7th of the short term disability benefit amount for each day of total disability.

When do these benefits stop?

Benefits will stop on the earliest of:

- The date you return to work;
- The date you are determined to be no longer disabled;
- The end of the Plan's maximum benefit period;
- The date your Employment in the Industry ends;
- The date of your retirement;
- The date of your death.

Benefits paid for the treatment of substance abuse will stop when you cease to participate in a rehabilitation program under the supervision of the Member

Assistance Program, or when you cease to comply with any other continuing treatment requirements as determined by the Funds in its sole discretion.

What happens if I return to work and become disabled again?

If you are disabled, return to work, and become disabled again due to the same or a related cause, the second disability will

be considered a continuation of the first period of disability, as long as you had returned to work for less than seven calendar days.

If your second disability is unrelated to the first, and you have returned to work, the second period of disability will be considered a separate claim and a new Elimination Period must be satisfied before benefits will become payable.

REPORTING A SHORT TERM DISABILITY CLAIM BY TELEPHONE



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WHEN TO REPORT A CLAIM

- If your physician has determined you are unable to work due to illness, injury or for maternity reasons;
- Thirty days in advance of a planned medical absence, such as prescheduled surgery or an expected maternity leave.
- If you are injured at work notify your employer immediately, unless it is an emergency. Do not use the toll-free number for work-related injuries.

TO REPORT A CLAIM

- See your physician and provide him or her with a signed and dated copy of the authorization form (located in the Personal Section). This form authorizes the release of medical information we need in order to process any benefit for which you may

be eligible;

- Call to initiate your claim. Refer to the check list on page 63 and call the toll-free number (800) 858-6843 to initiate your claim request.
- If your inability to work is a result of substance abuse, call the Member Assistance Program at 1-877-595-5282 for referral to a substance abuse professional.
- Fax or mail a copy of the completed authorization to the UnumProvident Benefits Center.

UnumProvident recognizes that a disabling illness or injury can create emotional, physical and financial challenges. We want you to feel confident in knowing that UnumProvident is committed to providing you with specialized expertise and responsive service.

FRAUD WARNING FOR HRSA-ILA PARTICIPANTS

Making a fraudulent claim for benefits may result in the termination of your benefit eligibility by the Board of Trustees of the HRSA-ILA Welfare Fund.



INFORMATION NEEDED TO SUBMIT A CLAIM

The following information may be required when you make your claim request. Please be prepared. If someone else makes the call on your behalf, he or she will need to provide this information.

- Policyholder's Name: HRSA-ILA Welfare Fund.
- **Policy Number: 564405;**
- Physician's name, address, fax and phone number;
- Your Name and Social Security Number, or employee ID number;
- Complete address and phone number;
- Date of birth;
- Marital status;
- Occupation (or job title);
- A brief description of your medical condition including cause of your condition (illness or injury), date of injury or beginning of illness and whether it's work-related;
- The dates of your first visit, your most recent visit, and your next scheduled visit with your physician for this condition;
- Your last day worked and your first day absent from work due to this condition;
- The date you expect to return to work (if you know), or the actual date if you have already returned to work at the time you call;
- Work restrictions or limitations advised by your physician, if any.

Prompt and complete information from you and your physician will help assure a timely decision and payment if you are eligible.

SUBROGATION AND REIMBURSEMENT FOR HRSA-ILA PARTICIPANTS

If you recover damages or receive a settlement from a third party as a result of an accident, the Subrogation and Reimbursement Policy of the HRSA-ILA Welfare Fund applies and you are required to repay weekly income benefits you received. If your application for Short Term Disability benefits is as a result of an accident for which recovery from a third party may be sought, call HRSA-ILA at (757) 457-7090 and request a copy of a Promissory Note, which you are required to sign.

FRAUD WARNING FOR VIRGINIA RESIDENTS

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**HRSA-ILA Welfare Fund
STD Policy # 564405
Claims administered by:
UnumProvident Benefits Center**

UnumProvident Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
Toll-free Number (800) 858-6843
Fax Number (800) 494-4516
www.unumprovident.com

You may not receive short term disability benefits during any period for which you are receiving workers' compensation benefits even if the medical conditions giving rise to the claims are completely unrelated.

A copy of the UnumProvident Authorization Form to be submitted to your health care provider is located in the Personal Section of your Summary Plan Description.

PROCEDURES FOR DISABILITY CLAIMS AND APPEALS

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your plan documents. If you have any questions about what to do you should contact us directly.

CLAIMS PROCEDURES

We will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if we both determine that such an extension is necessary due to matters beyond the control of the Plan and notify you of the circumstances requiring the extension of time and the date by which we expect to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, we may decide your claim without that information.

If your claim for benefits is wholly or partially denied, any notice of adverse benefit determination under the Plan will

- state the specific reason(s) for determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination and your right to obtain information about those procedures and the right to sue in federal court; and
- disclose any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of Notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If we determine that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). We will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, we may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. The review will be conducted by us and will be made by a person

different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, we will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, we will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the appeal determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing your right to bring a civil suit under federal law;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- a statement that “You or your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

IF YOU RECOVER DAMAGES OR RECEIVE A SETTLEMENT FROM A THIRD PARTY AS A RESULT OF AN ACCIDENT, THE SUBROGATION AND REIMBURSEMENT POLICY OF THE HRSA-ILA WELFARE FUND APPLIES AND YOU ARE REQUIRED TO REPAY WEEKLY INCOME BENEFITS YOU RECEIVED.

SUBROGATION AND REIMBURSEMENT

If the Welfare Fund pays short term disability payments for a participant relating to an injury or sickness for which a settlement is received from a third party, the Fund will assert a claim and lien against the settlement in the amount of the benefits paid. If the participant receives a payment in whole or in part from a third party or insurance carrier, the participant agrees to reimburse the Welfare Fund for the amount of benefits paid. Examples include automobile accidents and Workers' Compensation claim settlements. The Welfare Fund also has the right to seek reimbursement from the third party (or his, her, or its insurance company) for the amount of benefits paid.

You must notify the Funds whenever benefits are paid by the Welfare Fund that arise out of any injury or illness that provides or may provide the Welfare Fund subrogation rights. Failure to provide necessary information or to reimburse the Welfare Fund within seven days after recovery of any sum may disqualify you from future benefits under the Plan. If we request you to do so, you must complete any documents or forms we need in order to help us obtain reimbursement.

The Fund's subrogation rights and reimbursement help us hold down the Fund's costs for providing benefits and helps ensure that we may continue to provide health care benefits for you and the other participants.

INTRODUCTION

The HRSA-ILA Welfare Fund provides life insurance described on the following pages for Employees covered under the life insurance program (the “Plan”). Life insurance coverage is provided by UnumProvident under Group Policy H-974. This booklet summarizes the principal provisions of the Plan. Employees become covered under the Plan as provided on the coverage pages.

This section describes the Life Insurance Plan in effect for Active and Retired Employees and their spouses and dependents.

SCHEDULE OF BENEFITS FOR ACTIVE EMPLOYEES

LIFE INSURANCE FOR ACTIVE EMPLOYEES

The annual effective date for life insurance is October 1 of each contract year. The amount of life insurance that you qualify for is based upon your work hours in the prior contract year. Any changes in the amount of insurance will become effective on October 1.

Life Insurance

| HOUR CREDITS | AMOUNT OF INSURANCE |
|-------------------------------------|---------------------|
| 1,000 hours thru 1,299 credit hours | \$40,000 |
| 1,300 hours thru 1,599 credit hours | \$70,000 |
| 1,600 hours and more | \$100,000 |

In the first year of employment, an employee with no life insurance coverage at the beginning of the contract year (October 1 - September 30) will be insured for \$40,000 for the remainder of the contract year as soon as 1,000 hours are worked.

SCHEDULE OF BENEFITS FOR RETIRED EMPLOYEES

LIFE INSURANCE FOR RETIREES AGE 62 AND OLDER

Amount of Insurance

\$15,000

In the event of your retirement prior to the age of 62, your life insurance will be continued in an amount equal to the amount of insurance you qualified for before retirement with a minimum of \$15,000 and a maximum benefit of \$40,000. At age 62 your life insurance amount reduces to \$15,000. Employees under the age of 62 who retire having earned less than 1,000 hours during the year of or the year prior to their year of retirement will qualify for a death benefit of \$15,000.

SCHEDULE OF BENEFITS FOR YOUR DEPENDENTS

LIFE INSURANCE FOR YOUR DEPENDENTS

| | AMOUNT OF INSURANCE |
|--|---------------------|
| Your eligible spouse | \$ 5,000 |
| Each of your children based on age at death: | |
| • Less than 6 months | \$ 100 |
| • 6 months but less than 2 years | 200 |
| • 2 years but less than 3 years | 400 |
| • 3 years but less than 4 years | 600 |
| • 4 years but less than 5 years | 800 |
| • 5 years but less than 21 years | 1,000 |

GENERAL INFORMATION

DEATH BENEFIT

In the event of your death while covered, the amount of your Life Insurance stated in The Schedule of Benefits is payable to the person(s) whom you have named as your beneficiary on your Beneficiary Form filed with the Plan. If multiple primary beneficiaries are named and one or more predeceases you, the benefit will be distributed pro rata to the remaining designated primary beneficiaries. A designated secondary beneficiary will receive a distribution only upon the death of all named primary beneficiaries. If you have not selected a beneficiary, your Life Insurance will be paid to your spouse, if married, or to your estate. In the event of divorce, your designation of your former spouse as beneficiary shall automatically be terminated, unless you re-designate that person as your Designated Beneficiary.

The Life Insurance Death Benefit is paid by UnumProvident upon receipt of a Proof

of Death Claim, a certified copy of the Death Certificate, and a copy of the Beneficiary Form. To be considered for payment, a Proof of Death Claim must be filed within one year after the death of the insured.

In the event of the death of a covered Dependent, the amount of your Dependent's Life Insurance stated in the Schedule of Benefits is payable to you.

INSTALLMENT SETTLEMENT

You may have all or part of your Life Insurance paid in equal monthly installments of a fixed amount, determined in accordance with the provisions of the Group Policy. If you do not elect payment in installments, your beneficiary may make such election at your death.

The Dependents' Life Insurance is payable in one sum.

BENEFICIARY

Be sure you have named the person who is to be your beneficiary on a Beneficiary Form on file with HRSA-ILA.

You may select or change your beneficiary by:

- Completing the required Beneficiary Form furnished in the Personal Section of this notebook; or
- Calling the HRSA-ILA Interactive Voice Response System, (757) 423-3090, selecting option 5 to request a Beneficiary Form; and
- Returning the completed form to HRSA-ILA.

Power of Attorney

If you have given someone power of attorney, that person will not be able to change your beneficiary unless you have actually granted that person the specific authority in the “Power of Attorney” document to make beneficiary decisions for you. Generally, a guardian or committee will not have the authority to change your beneficiary.

LIFE CONVERSION PRIVILEGE

UPON TERMINATION OF INSURANCE

If your insurance is terminated because of termination of employment or failure to requalify in the eligible classes or when the amount is reduced at age 62, you may convert your group life insurance without medical examination or other evidence of insurability,

- To any individual life policy then customarily issued by UnumProvident (except term insurance);
- By applying to UnumProvident within 31 days after termination of insurance and paying the premium applicable to the form and amount of the policy at your then attained age; and
- In any amount up to the amount for which you were insured.

If your insurance is terminated due to discontinuance of this Plan you will have this conversion privilege if you have been insured under this Plan for 5 years or longer, except that the amount of the individual policy may not exceed \$2,000 and may not include any amount you become eligible for under any other group plan within the 31 days.

If your spouse is covered for life insurance as your dependent, he or she will have the same right of conversion as you have.

The life insurance is payable if you or your spouse die within the 31 day period allowed for conversion whether or not application for an individual policy has been made.

ACCIDENTAL DEATH & DISMEMBERMENT

SUMMARY OF COVERAGE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR ACTIVE EMPLOYEES

This benefit is part of the Welfare Fund and is underwritten by Reliance Standard Life. This benefit is for active employees only. Spouses and dependent children are not eligible for this benefit. Coverage for a retiree ends at the end of the contract year following when they last worked 1000 or more hours.

Benefits payable under this policy will be paid to the person whom you have named as your Beneficiary on your Beneficiary Form filed with the Plan.

Description of Coverage

If within one year after the date of a covered accident any of the losses shown below should occur as a result of that accident, Reliance Standard Life will pay the benefits listed below to the named beneficiary. To be considered for payment, a Proof of Loss claim statement must be filed within one year after the death of the insured.

| ACCIDENT LOSSES | COVERAGE |
|--|------------------------------|
| Loss of Life | The Principal Sum |
| Loss of Two or More Members * | The Principal Sum |
| Loss of Speech and Hearing | The Principal Sum |
| Loss of One Member * | One-Half The Principal Sum |
| Loss of Speech or Hearing | One-Half The Principal Sum |
| Loss of Thumb and Index Finger of Same Hand | One-Fourth The Principal Sum |

“The Principal Sum” is an amount equal to the active employee’s life insurance benefit (see page 69)
*“Member” means a hand, foot or eye.

EXCLUSIONS

This plan and the policy do not cover any loss:

- caused by or resulting from war or any act of war; or
- from an accident that occurs while in the armed forces of any country, except in certain instances while participating in a Reserve Corps or National Guard Unit;
- to which sickness or disease is a contributing factor; or
- caused by intentionally self-inflicted injuries including without limitation injuries from abuse of alcohol and drugs; or
- caused by suicide; or
- losses sustained as result of an act of physical aggression initiated by the employee against another person;
- caused by or resulting from riding in, getting into or out of any aircraft, unless:
 - (1) the aircraft is any tested and approved civilian aircraft;
 - (2) the aircraft is being used at the time for transportation of passengers; and
 - (3) the aircraft is operated by the then current rules of the authority having jurisdiction over the operation of the aircraft.

Benefits payable under this policy will be paid to the person whom you have named as your beneficiary on your Beneficiary Form filed with the Plan. If multiple primary beneficiaries are named and one or more predeceases you, the benefit will be distributed pro rata to the remaining designated beneficiaries. Only upon the death of all named primary beneficiaries will the secondary beneficiary receive a distribution.

If you have not selected a beneficiary, your benefit will be paid to your spouse, if married, or to your estate. In the event of divorce, your designation of your former spouse as beneficiary shall automatically be terminated, unless you re-designate that person as your Designated Beneficiary.

WELLNESS PROGRAM

A Wellness Program offered by the HRSA-ILA Welfare Fund to its participants includes:

YMCA MEMBERSHIP

Members may join the YMCA at no charge for individual memberships and may self-pay to upgrade to a Family Membership at a reduced monthly fee. A requirement of the free membership is that you must commit to participating in a YMCA exercise program at least 6 times per month and you must complete a Sentara Health Risk Appraisal. If you fail to adhere to the requirements of the free YMCA membership, your membership will be terminated and you will not be permitted to rejoin for 6 months.

HEALTHY EDGE MEMBERSHIP

The HRSA-ILA contracts with Sentara for the Healthy Edge Program. Members may join at no charge by calling 455-7236. With membership you receive:

- Blood Pressure and Cholesterol Screenings during seasonal Health Fairs located at the HRSA-ILA Funds Benefit Center;
- Special Newsletters on wellness tips;
- Copy of the Healthwise Handbook;

- Annual mammograms;
- Free participation in classes such as Smoking Cessation, Healthy Heart, Exercise and Nutrition. You can look for a notice of classes offered each quarter in the HRSA-ILA Port Call newsletter; and
- Free Flu Shots given yearly.

NOTE:

Wellness Programs carry the same eligibility requirements and effective date of coverage as Dental & Vision Benefits.

For example:

Hours earned between the dates of October 1 and September 30 (any given contract year) are credited for Benefits. Coverage does not begin until January 1 of the following year and remains effective throughout the calendar year.

ADDITIONAL WELLNESS RESOURCES:

www.ymcashr.org
www.sentara.com

MEDICARE “PART B” PREMIUM REIMBURSEMENT

MEDICARE “PART B” PREMIUM REIMBURSEMENT

A Retiree who qualifies for MILA and HRSA-ILA Welfare benefits who is enrolled in Medicare will be reimbursed for the Medicare Part B premium. If the participant is retired, the eligible spouse of the retiree who is enrolled in Medicare will be reimbursed for the Part B premium. Reimbursement will begin on the date of enrollment provided you submit a copy of your Medicare card within 90 days; or if after 90 days, beginning on the first of the month when you submit your card. Payments will be distributed to the member on a quarterly basis on or about January 10th, April 10th, July 10th and October 10th.

Once a member or their eligible spouse qualifies for Medicaid these reimbursement payments will end. You are responsible for informing the Plan when you qualify for Medicaid. You will be required to reimburse the Plan for any Medicare premium reimbursement that you received after your coverage by Medicaid.

ADMINISTRATION OF THE PLAN

WHO PAYS FOR THE PLAN

The Plan is funded from contributions made by the Employers to the Trustees of the HRSA-ILA Welfare Fund on the basis of hours worked by Employees covered by the Collective Bargaining Agreement between the Employer-Members of the Hampton Roads Shipping Association and the International Longshoreman's Association.

Welfare Fund benefits for retired members may be funded from time to time by the 401(h) account at the discretion of the Board. The 401(h) account will only supplement funding and will never provide duplicate funding of Welfare Fund benefits.

PLAN IDENTIFICATION NUMBERS

A summary description of the Plan is on

file with the U.S. Department of Labor and may be referred to by the Employer Identification Number (EIN) 54-0489826 and Plan Number 501.

UNION AGREEMENT

This Plan is maintained pursuant to the Collective Bargaining Agreements. You may obtain a copy of any agreement by sending a written request to the Plan Administrator. You may examine any such agreement during normal office hours at the office of the Plan Administrator.

The benefits, conditions for eligibility, and qualifications and limitations of coverage under the plan are described in this booklet, which is given to all employees who are plan participants. If your booklet is misplaced, you may obtain a replacement from the Plan Administrator.

| PLAN NAME | TRUSTEES | PLAN YEAR | PLAN NUMBER | PLAN ADMINISTRATOR AND ADDRESS |
|-----------------------|--|-------------------------|-------------|--|
| HRSA-ILA Welfare Fund | As listed in the Administration Section Page 7 | Oct. 1 through Sept. 30 | 501 | Board of Trustees HRSA-ILA Welfare Fund 1355 Terminal Blvd. Norfolk, VA 23505 Phone (757) 457-7090 800-899-3090 |

IMPORTANT NAMES AND ADDRESSES

PLAN ADMINISTRATOR

The Plan Administrator is the Board of Trustees of the HRSA-ILA Welfare Fund. The Plan Administrator has authority to control and manage the operation and administration of the Plan.

- 1355 International Terminal Blvd.
Norfolk, Virginia 23505-1468
Phone Number - (757) 457-7090

AGENT FOR SERVICE OF LEGAL PROCESS

- The Board of Trustees
HRSA-ILA Welfare Fund
1355 International Terminal Blvd.
Norfolk, Virginia 23505-1468

The Plan Administrator or any of the Trustees named in the ERISA Rights section also may be served with legal process.

**THE HRSA-ILA BOARD OF TRUSTEES MAY
TERMINATE, SUSPEND, WITHDRAW, AMEND OR
MODIFY THE WELFARE FUND IN WHOLE OR IN PART
AT ANY TIME.**