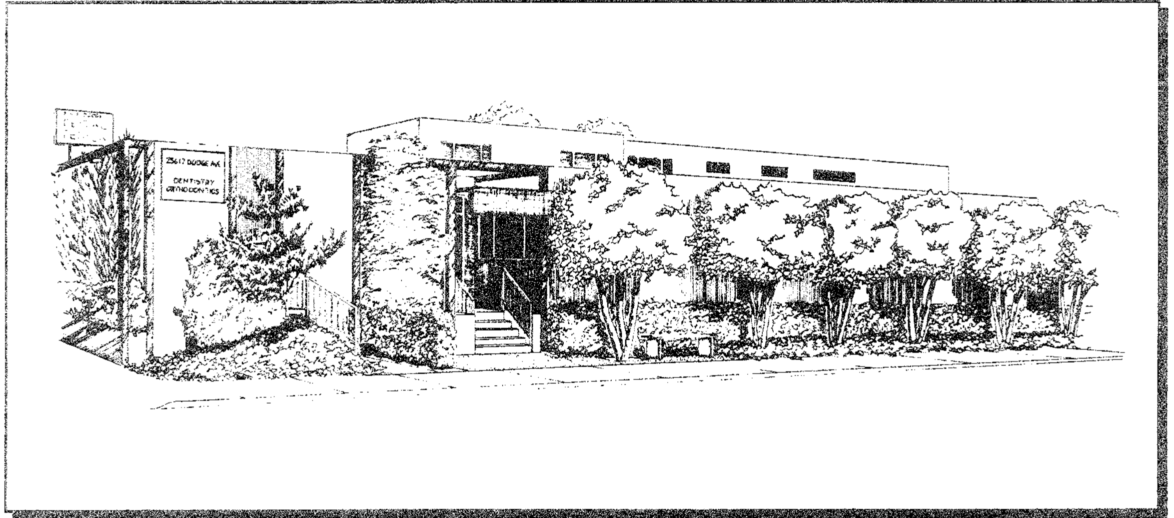
ADULT & CHILDREN'S DENTAL PROGRAMS



Harbor
Dental
Associates

ILWU-PMA WELFARE PLAN
1188 FRANKLIN STREET, SUITE 300
SAN FRANCISCO, CA 94109
(415) 673-8500

SUPPLEMENTAL SUMMARY
PLAN DESCRIPTION
HARBOR DENTAL ASSOCIATES
DENTAL PROGRAM
LOS ANGELES LOCALS 13, 26, 63 AND 94

A SUPPLEMENTAL SUMMARY PLAN DESCRIPTION OF HARBOR DENTAL ASSOCIATES DENTAL PROGRAM FOR ELIGIBLE PERSONS IN LOS ANGELES LOCALS 13, 26, 63, AND 94

(Applicable to both Adult and Children's Programs)

This is a general description of the Dental Program established in accordance with the provisions of the Group Dental Agreement between the Trustees of the ILWU-PMA Welfare Plan and Harbor Dental Associates (hereafter referred to as the Dentists Group). This booklet is only a summary and does not describe every provision of the Group Dental Program. This booklet cannot modify or affect the Group Dental Agreement, nor shall you accrue any rights because of any statement in or omission from this booklet.

ELIGIBILITY

To receive benefits under the Dentists Group Dental Program, you must:

(1) be eligible under the terms of the ILWU-PMA Welfare Plan; and

(2) choose the Dentists Group Dental Program as your dental benefit provider.

Welfare Plan eligibility requirements are explained in the Summary Plan Description booklet provided to all Plan participants.

The following eligible active employees and pensioners and their dependents are entitled to dental benefits:

- Active Longshoreman, Ship Clerks, Walking Bosses/Foremen and Watchmen.
- Pensioners under the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan and certain Social Security retirees.
- Dependent spouses.
- Unmarried dependent children up to age 19.
- Unmarried dependent children age 19 to 23 who are full-time students.
- Unmarried dependent children age 19 or over who are incapacitated by physical or mental handicap when they attain age 19 and who are incapable of self-sustaining employment.
- Qualified surviving spouses and dependent children of eligible active and retired employees.

LOSS OF ELIGIBILITY

Eligibility under the Dentists Group ends upon:

- Loss of eligibility under the ILWU-PMA Welfare Plan.
- Election of an alternate dental plan.

CHOICE OF PLANS

Eligible persons in the Los Angeles area are offered a choice between the Dentists Group and an alternate plan, Delta Dental Plan of California. The choice is offered when eligibility is first obtained, and each year in May for coverage effective July 1. In addition to the May open enrollment period, participants may change their dental plan coverage once at any time during the Plan Year (July 1 - June 30). Information about the choice is furnished by the Welfare Plan office.

HOW TO USE YOUR DENTAL PROGRAM

All dental services are provided at the Dentists Group offices of:

Harbor Dental Associates
25617 Dodge Avenue
(At Pacific Coast Highway)
Harbor City, CA 90710
Phone: (310) 835-3144

Or, at the offices of:

Dr. James Tate
8540 So. Sepulveda Blvd., Suite 815
Los Angeles, CA 90045
Phone: (310) 410-9470

You must go to the offices listed above to receive treatment under the Dentists Group Dental Program.

The dental offices are open daily (except Sunday) from 8:30 A.M. to 5:30 P.M. Telephone (310) 835-3144 for an appointment. In case of emergency, a visit will be scheduled immediately.

No identification card is necessary, there are no insurance forms to complete, and no prior authorization for treatment is required.

BENEFITS PROVIDED BY THE PROGRAM

Your Program covers the following services when they are provided by the Dentists Group. Covered services are provided at no cost to the patient, except for the 10% copayment for Orthodontic services, and except as otherwise provided in the sections called "Limitations," "Exclusions," and "Emergency Out-of-Area Benefit."

I. DIAGNOSTIC AND PREVENTIVE BENEFITS

Diagnostic
: Oral examination, x-rays (see Limitations), study models, biopsy/tissue examination, emergency palliative treatment, specialist consultation (when referral is from the Dentists Group).

Preventive
: Prophylaxis (cleaning), fluoride treatment, space maintainers.

II. BASIC BENEFITS

Oral Surgery
: Extractions and certain other surgical procedures, including pre- and post-operative care.

Restorative
: Amalgam, synthetic plastic or resin restorations (fillings) for treatment of cavities (decay).

General Anesthesia
: When administered by a dentist for a covered oral surgery procedure.

Endodontic
: Treatment of the tooth pulp.

Periodontic
: Treatment of the gums and bones supporting teeth.

III. CROWNS, JACKETS AND GOLD OR CAST RESTORATIONS

Crowns, jackets and gold or cast restorations are benefits only if they are provided to treat cavities that cannot be restored with amalgam, synthetic, plastic or resin fillings (see Limitations and Exclusions).

IV. PROSTHODONTIC BENEFITS

Construction or repair of fixed bridges, partial and complete dentures are benefits if provided to replace missing, natural teeth (see Limitations and Exclusions).

In addition to the covered services listed above, the following benefits are provided under the Children's Program only:

ORTHODONTIC BENEFITS

(Provided only for unmarried dependent children under age 19.) Treatment necessary for the correction of malpositioned teeth. The orthodontic benefit is 90% of usual, customary and reasonable charges.

SEALANTS

(Provided only to dependent children under age 14.)

Sealants will only be applied to permanent molars with no decay, with no restorations, and with the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within 3 years of its application.

EMERGENCY OUT-OF-AREA BENEFIT

If an eligible patient has a dental problem of an emergency nature when more than twenty-five (25) miles from the Dentists Group office, the Program will, upon presentation of a paid statement, reimburse the cost of only such emergency service as is necessary to alleviate the problem, up to a maximum of fifty dollars ($50).

LIMITATIONS

Covered services listed in this brochure are subject to the following limitations:

Unless special need is shown, full-mouth x-rays will not be provided until 5 years have elapsed following any prior provision of full-mouth x-rays. Supplementary bitewing (individual) x-rays may be provided, but not more than once every six months for children or once every twelve months for adults age 18 and over.

The Dentists Group will cover the total cost of treatment procedures which are necessary and customary by standards of generally accepted dental practice. However, should you select a more expensive plan of treatment (e.g., a gold crown where a silver filling could restore the tooth), then the Dentists Group will cover the fee applicable for the lesser procedure and the patient will be responsible for the remainder of the fee.

Crowns, jackets and gold or cast restorations: Replacement will be made at any time if, in the opinion of the Dentists Group, said crown, jacket, or gold or cast restoration is unsatisfactory.

Prosthodontics: Replacement will be made of a prosthodontic appliance only if it is unsatisfactory and cannot be made satisfactory. Prosthodontic appliances (including but not limited to partial and complete dentures and fixed bridges) will be replaced only after five (5) years have elapsed following any prior provision of such appliances, except when there is such extensive loss of remaining teeth or change in supporting tissue that the existing appliance cannot be made satisfactory.

Occlusion: The Dentists Group will generally cover the cost of restorations required to replace missing teeth. Procedures, appliances or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional and the cost is the responsibility of the patient. The cost will be that cost which is listed as usual, customary and reasonable and currently being charged by the Dentists Group to patients not covered by this agreement. Such procedures may include, but are not limited to, equilibration, periodontal splinting, restoration of tooth structure lost from attrition, and restoration for malalignment of the teeth.

Implants: If implants are required and utilized, the Dentists Group will allow the cost of a standard complete denture toward the cost of a full subperiosteal implant and appliances constructed in association therewith (a single arch). In unilateral or single tooth implants, the Dentists Group will allow the cost of a standard unit of gold (a crown or pontic) toward the cost of the implant and appliance constructed therewith. The Dentists Group does not provide for the cost of the surgical removal of implants.

The cost of any item or procedure for which the patient might have to pay will be that cost which is listed as usual, customary and reasonable and currently being charged by the Dentists Group for the item or procedure to patients not covered by this agreement.

EXCLUSIONS

The following services are *not covered.*

Services for injuries or conditions compensable under workers' compensation or similar employer liability laws.

Services provided without cost by any federal or state government agency, county or municipality, except Medi-Cal benefits.

Services provided for cosmetic reasons only.

For adults only, services with respect to congenital (hereditary) or developmental (following birth) malformations, including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).

Prosthodontics or any other procedures started prior to the date of eligibility for services under this program.

Implants that are deemed inappropriate in the judgement of the Dentists Group.

Prescribed drugs.

Orthodontic services, except for covered, unmarried, dependent children under age 19

Repairs and/or replacement of removable orthodontic appliances previously furnished.

Services with respect to disturbances of temporomandibular joint (TMJ).

Experimental procedures.

All hospital costs.

Extra oral grafts (grafts of tissue from outside the mouth to oral tissues).

Sealants, except for covered dependent children under age 14.

Services otherwise provided under the ILWU-PMA Welfare Plan.

COORDINATION OF BENEFITS (DUAL COVERAGE)

In order to avoid duplication of payment for the same services, the benefits of the Dental Program are coordinated with other programs which are not paid for by the member and which provide dental benefits. Generally, if a patient is covered by more than one dental program, expenses are shared between the programs up to the full amount of the actual cost.

EXTENSION OF BENEFITS

All benefits cease on the date coverage terminates, except that the Dentists Group will complete single dental procedures (other than orthodontic services) which were commenced prior to the date on which coverage terminates.

THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE DENTISTS GROUP DENTAL PLAN. THE DENTISTS GROUP DENTAL PLAN CONTRACT DETERMINES THE EXACT TERMS AND CONDITIONS OF COVERAGE.

CLAIMS REVIEW PROCEDURES

The procedures described below apply to requests for benefits under the dental program. Please note that a mere inquiry about whether a particular item is covered under the Plan is not a claim for this purpose.

Claim Denial

If a claim is denied or partly denied by the Dentists Group, notice will be given to the claimant in writing. The notice will be written in understandable language and will state:

- Specific reasons for denial of the claim;
- Specific reference to provisions of the Welfare Agreement, the Dental Program, or contract provisions upon which the denial is based;
- A description, if appropriate, of additional information or material which might enable the claimant to perfect the claim;
- An explanation of how, where and when the claimant may obtain a review of the denial;
- If the denial is based on an internal rule, guideline or protocol, the claimant has the right to request a free copy of the rule guideline, or protocol; and
- If the denial is based on a determination that the treatment or services are not considered to be standard dental treatment (e.g., are considered experimental), the claimant has the right to request a free copy of the scientific or clinical judgement on which such determination is based.

Notice of claim denial must be given to the claimant within a reasonable period of time, but not later than 30 days after the date the claim is received. This period may be extended an additional 15 days if the Dentists Group determines that an extension is necessary due to matters beyond its control and the claimant is notified of the extension before the end of the initial 30-day period and the date by which the Dentists Group expects to render a decision on the claim. If an extension is required because the claimant failed to submit sufficient information to enable the Dentists Group to make a determination of the claim, the notice of the extension will also describe the additional information required. In such a case, the claimant will be given at least 60 days to provide the additional information. The period from the date the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

If the Dentists Group does not respond to the claimant's claim within the time periods specified above, the claimant may deem his claim denied for this purpose as of the expiration of the applicable time period above.

Any dispute which is not settled by these procedures is subject to arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association in Los Angeles. Any party to a dispute, including the patient's representative, may initiate arbitration by written notice to each other party to the dispute stating the intention to arbitrate and describing the nature of the dispute, the dollar amount involved, if any, and the remedies sought and by filing two copies of such notice with the American Arbitration Association Regional Office in Los Angeles together with the fee required by the Association.

Request for Claim Review by Trustees of the ILWU-PMA Welfare Plan

Within 180 days after notice that a claim has been denied by the Dentists Group, or after the claim is deemed denied as provided above, the claimant or his/her representative may make a written request for a review of the denial by the Trustees of the ILWU-PMA Welfare Plan. The claimant or his/her representative may request copies free of charge, of all documents, records and other information relevant to the claim. This includes documents relied on in making the benefit determination or submitted or generated in the course of the review.

A request for a review by the Trustees must be submitted to:

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 300
San Francisco, CA 94109

Decision on Review by Trustees of the ILWU-PMA Welfare Plan

The Trustees of the ILWU-PMA Welfare Plan, or a committee of the Trustees, will render their decision on the claim within 60 days of receipt of the request for review.

The decision of the Trustees will be communicated in writing, and in understandable language. It will include specific references to the Welfare Agreement or contract provisions upon which the decision is based.

If the Trustees do not respond to the claimant's request for review within the time periods specified above, the claimant may deem his claim denied on review for this purpose as of the expiration of the applicable time period above.

Request for Arbitration

After notice that a claim has been denied by the Trustees on review, or after the claim is deemed denied on review as provided above, the claimant may request that the claim be decided by the Coast Arbitrator. In order to obtain a review of a claim by the Coast Arbitrator, the claimant must have obtained a prior determination on the claim by the Trustees (or a deemed denial) in accordance with the procedures outlined above. The claimant or his/her representative may request copies, free of charge, of all documents, records and other information relevant to the claim. This includes documents relied on in making the benefit determination or submitted or generated in the course of the review by the Trustees.

A request for a review by the Coast Arbitrator must be submitted to:

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 300
San Francisco, CA 94109

Decision by Coast Arbitrator

The Coast Arbitrator will render a decision on the claim within 30 days of receipt of the request for review. The decision of the Coast Arbitrator will be communicated in writing, and in understandable language. It will include specific references to the Welfare Agreement or contract provisions upon which the decision is based.

Judicial Review

A claimant has the right to file a suit in a court of law if a claim is denied or partly denied by the Coast Arbitrator. Plan provisions and applicable law require, however, that the claimant first exhaust all of his or her appeal rights under the Plan. This means that a claimant must obtain determinations by the Trustees and by the Coast Arbitrator before he or she may file a lawsuit for a benefit under the Plan.

COBRA CONTINUATION COVERAGE

Persons who lose ILWU-PMA Welfare Plan eligibility will be informed by the Welfare Plan office if they are entitled to COBRA continuation coverage.

COBRA is the nickname of a federal law which required the temporary extension of certain Welfare Plan benefits to Plan participants and family members when coverage under the Plan ends.

COBRA continuation coverage is self paid, that is, the eligible person must pay for coverage. The cost is the same as the cost to the Plan of group coverage, plus a 2% administrative fee. It can generally be purchased for up to 18 to 36 months, depending on the reason for loss of group coverage.

A brochure about COBRA has been furnished to the locals and is available from the Welfare Plan office upon request.

PLAN SPONSOR:

Trustees of ILWU-PMA Welfare Plan

EMPLOYER IDENTIFICATION NUMBER:

94-6068578

PLAN NUMBER: 501

NAME AND ADDRESS OF PLAN ADMINISTRATOR:

Trustees of ILWU-PMA Welfare Plan
1188 Franklin Street, Suite 300
San Francisco, CA 94109
(415) 673-8500

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS:

Executive Director
ILWU-PMA Welfare Plan
1188 Franklin Street, Suite 300
San Francisco, CA 94109

(Service of legal process may also be made upon a Plan Trustee or on the Plan Administrator.)

PLAN FISCAL YEAR ENDS: June 30

NAME AND ADDRESS OF EMPLOYER:

ILWU-PMA Welfare Plan
1188 Franklin Street, Suite 300
San Francisco, CA 94109

NAMES OF TRUSTEES:

Union Trustees	Employer Trustees
Robert M. McEllrath	Ronald J. Forest
Ray Ortiz, Jr.	Robert L. Stephens
Joseph Wenzl	Michael H. Wechsler

Each participant of the ILWU-PMA Welfare Plan has been provided with a Summary Plan Description, as required by ERISA (Employee Retirement Income Security Act). The Summary Plan Description describes the Plan, its eligibility requirements and benefits. It also informs the participants about Supplemental Summary Plan Descriptions pertaining to individual health care programs. The Summary Plan Description and Supplemental Summary Plan Descriptions are available from the Plan office upon request.