INTERNATIONAL
LONGSHOREMEN'S
&
WAREHOUSEMEN'S
UNION —
PACIFIC
MARITIME
ASSOCIATION

SUMMARY PLAN DESCRIPTION

ILWU-PMA WELFARE PLAN

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INTERNATIONAL LONGSHOREMEN'S & WAREHOUSEMEN'S UNION — PACIFIC MARITIME ASSOCIATION

SUMMARY PLAN DESCRIPTION

ILWU-PMA WELFARE PLAN

This booklet summarizes the eligibility and benefits of the ILWU-PMA Welfare Plan. The booklet does not describe eligibility requirements and benefit provisions in complete detail. The information in this booklet is subject to, and in no way modifies or interprets, the provisions of the ILWU-PMA Welfare Agreement and the provisions of policies of insurance and contracts between the Welfare Plan Trustees and the insurance carriers and providers of care.

This booklet and the Supplemental Summary Plan Description booklets mentioned on page 21 together summarize the provisions of the ILWU-PMA Welfare Plan through the 1993-1996 ILWU-PMA collective bargaining agreement.

TABLE OF CONTENTS

ILWU-PMA Welfare Plan programs for eligible longshoremen, ship clerks, walking bosses/foremen and watchmen*, and their qualified dependents, are established by collective bargaining between the International Longshoremen's & Warehousemen's Union (ILWU) and Pacific Maritime Association (PMA). The Welfare Plan provides the following types of benefits: health care (including hospital-medical-surgical care, prescription drugs, vision care, hearing aids, and dental care), death and accidental death and dismemberment, time loss (weekly indemnity and supplemental disability), alcoholism/drug recovery, and Social Security supplementation. Please see the Table of Contents for reference to Plan eligibility, benefit programs, claims review procedures, and general information.

Welfare Plan provisions are set forth in the Third Amended ILWU-PMA Welfare Agreement, as amended, which is the collective bargaining agreement under which the Plan is maintained. To the extent this booklet is inconsistent with the Agreement, the Agreement shall govern. Copies of the Agreement are on file at the Welfare Plan office, are furnished to ILWU Locals, and are available to participants and beneficiaries upon request.

**NOTE: Watchmen, as the term is used in this booklet, refers only to watchmen who are eligible to participate in the ILWU-PMA Welfare Plan. It does not refer to watchmen who participate in the ILWU-PMA Watchmen Welfare Plan.*

WHO IS ELIGIBLE FOR ILWU-PMA WELFARE PLAN BENEFITS

Although each Welfare Plan program may have different and additional requirements for coverage, the Plan's basic eligibility is determined as follows:

■ Active Employees

A description of eligibility requirements for Active Employees begins on page 11.

■ Pensioners

Most Welfare Plan participants who become Pensioners under the ILWU-PMA Pension Plan and the ILWU-PMA Watchmen Pension Plan have Welfare Plan eligibility beginning on the day they become Pensioners. It is expected that eligibility will continue until the Pensioner loses eligibility as explained on page 17.

Under the ILWU-PMA Pension Plan: All disability Pensioners have Welfare Plan eligibility. Also, all Longshoremen who are registered when they retire on a normal pension with a separation date on or after July 1, 1984 have eligibility except for the following:

- Pensioners whose separation date was on or after July 1, 1988 and who accrued fewer than 5 years of credited pension service.
- Deferred Pensioners whose separation date was before age 55 or whose normal pension benefit has not commenced.

Under the ILWU-PMA Watchmen Pension Plan: All disability Pensioners have Welfare Plan eligibility. Also, Watchmen who are registered when they retire on a normal pension have eligibility, provided that such Pensioners with a separation date (a) on or after July 1, 1990 have accrued 10 or more years of credited pension service or (b) before July 1, 1990 have 13 or more years of service, and provided further that such Pensioners have met the

requirement of having worked in each of the 5 years preceding retirement.

Adult Survivor Pensioners

A surviving spouse receiving a Survivor Pension (but not an Early Survivor Annuity) under the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan has Welfare Plan eligibility for herself and qualified dependent children provided that the pension is claimed through a Pensioner who had Welfare Plan eligibility when he died, or through an active participant who would have been entitled to Welfare Plan eligibility as a Pensioner had he retired as of his date of death. Such a surviving spouse must have been identified by the Pensioner as a Dependent Spouse on the form provided by the Trustees (and such form must have been filed with the Trustees) as of the date of the Pensioner's death. Welfare Plan eligibility ends when the Adult Survivor Pensioner remarries.

Child Survivor Pensioners

A deceased Pensioner's Dependent Child has Welfare Plan eligibility as a Child Survivor Pensioner for the period that the child receives survivor pension benefits. A deceased Active Employee's Dependent Child who is eligible to receive a survivor pension has Welfare Plan eligibility for the period that survivor pension benefits are received. Such Child Survivor Pensioner must have been identified by the Longshoreman as a Dependent Child on the form provided by the Trustees (and such form must have been filed with the Trustees) as of the date of the Pensioner's death.

Surviving Dependent Spouse or Child

The Dependent Spouse or Child of a deceased eligible Active Employee, if such spouse is not an Adult Survivor Pensioner or if such child is not a Child Survivor Pensioner, and irrespective of whether such spouse is receiving an Early

Survivor Annuity under the ILWU-PMA Pension Plan, has Welfare Plan eligibility for four years immediately following the employee's death. Such Surviving Dependent Spouse or Child must have been identified by the Longshoreman as a Dependent Spouse or Dependent Child on the form provided by the Trustees (and such form must have been filed with the Trustees) as of the date of the Longshoreman's death. A Surviving Dependent Spouse may continue Welfare Plan coverage after the four year period has ended by purchasing it under terms and conditions determined by the Trustees. Welfare Plan eligibility ends when the Surviving Dependent Spouse remarries.

Dependents

The qualified Dependent Spouse and qualified Dependent Children of an eligible Active Employee or Pensioner are eligible for Welfare Plan benefits, provided such Dependent Spouse and Dependent Children have been identified as dependents by the Longshoreman on the form provided by the Trustees (and such form has been filed with the Trustees). (See definition of Dependent Spouse on page 34 and of Dependent Child on page 33.) Eligibility as a dependent shall continue as long as the person through whom the dependent claims remains eligible, or until the dependents themselves cease to be qualified for dependent status.

Surviving ERISA Spouse

A surviving spouse of a Pensioner who died on or after July 1, 1987, who was married to such Pensioner for at least one year as of the Pensioner's date of death, who was identified by the Pensioner as a Dependent Spouse on the form provided by the Trustees (and such form was filed with the Trustees) as of the date of the Pensioner's death, and who is not an Adult Survivor Pensioner (but who would have qualified as an Adult Survivor Pensioner under ERISA before the laws were changed in 1984), has Welfare Plan eligibility. Welfare Plan eligibility ends when a Surviving ERISA Spouse remarries.

Changes in family status which might affect Welfare Plan eligibility (such as marriage, final dissolution of marriage, birth, adoption, or death of a dependent) should be reported to the Plan office.

Note: Although the Trustees intend to provide eligibility for the lifetimes of participants and beneficiaries subject to the limitations set forth above and elsewhere in this Summary Plan Description, continued eligibility is subject always to the provisions of the ILWU-PMA Welfare Agreement and to ILWU-PMA collective bargaining.

■ MEDICARE ENROLLMENT

The Welfare Plan hospital-medical-surgical programs are integrated with primary Medicare coverage. Thus, retired members and their dependents with Welfare Plan eligibility must, if eligible, enroll in Part B of Medicare in order to maintain their eligibility for Welfare Plan hospital, medical and surgical benefits.

The Welfare Plan reimburses the cost of Medicare Part B premiums, unless otherwise reimbursed, to retired employees, survivors and dependents who are required to enroll in Medicare Part B in order to maintain Welfare Plan coverage.

Active employees and their dependents age 65 and over are covered primarily under the ILWU-PMA Welfare Plan until retirement, in accordance with federal law. Such persons will be required to enroll for Medicare Part B upon retirement, at which time the Welfare Plan office will advise them of the enrollment procedure.

HOW ELIGIBILITY FOR PLAN BENEFITS IS DETERMINED FOR ACTIVE EMPLOYEES

Only persons who have industry Registration may become eligible as Active Employees for Welfare Plan benefits. Following is a summary of the rules by which Active Employees' eligibility is established.*

■ Annual Review

The Trustees conduct a review of each registered Active Employee's employment record in covered employment for the Payroll Year preceding each July 1 to determine whether the employee has established eligibility for Welfare Plan coverage for the 12 months beginning as of such July 1.

Eligibility Rules for Major Ports: On July 1 of each year a registered Active Employee whose Assigned Port is a Major Port will be eligible during the succeeding 12 calendar months if he works or is credited with at least 800 hours in the preceding Payroll Year, or at least 400 hours in the last half of the preceding Payroll Year. (See definition of Assigned Port on page 33 and of Major Port on page 34.)

Eligibility Rules for Minor Ports: On July 1 of each year a registered Active Employee whose Assigned Port is a Minor Port will be eligible during the succeeding 12 calendar months if he works or is credited with at least 480 hours in the preceding Payroll Year, or at least 240 hours in the last half of the preceding Payroll Year. (See definition of Minor Port on page 34.)

■ Mid-year Review

The Trustees conduct a review of each *ineligible* registered Active Employee's employment record in covered employment for the first half of the Payroll Year preceding each January 1 to determine whether the employee has established

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* See note on page 14.

eligibility for Welfare Plan coverage for the 6 months beginning as of such January 1.

Eligibility Rule for Major Ports: On January 1 of each year a registered Active Employee whose Assigned Port is a Major Port will be eligible during the succeeding 6 calendar months if he works or is credited with at least 400 hours in the first half of the preceding Payroll Year.

Eligibility Rules for Minor Ports: On January 1 of each year a registered Active Employee whose Assigned Port is a Minor Port will be eligible during the succeeding 6 calendar months if he works or is credited with at least 240 hours in the first half of the preceding Payroll Year.

■ Pay Guarantee Plan Credits

A registered Active Employee who is eligible for payments under one of the Pay Guarantee Plans during a review period will be credited toward the hours requirement for eligibility with all payments for which he is eligible. The credit is determined by dividing the total amount of payments for which the employee is eligible during the review period by the hourly straight-time wage rate then in effect.

■ Disability Credits

If a disabling illness or injury prevents a registered Active Employee from meeting the hours requirement of an Annual or Mid-year Review for Welfare Plan eligibility, he may be credited with additional hours during the term of a certified disability.

1. A registered Active Employee who has been unable to meet the hours requirement for eligibility because of a certified disability, *but who has worked or been credited with at least 25% of the hours requirement of an Annual or Mid-year Review*, will be credited with additional hours during the review period as follows: the total number of credited hours will be the result of multiplying the number of weeks of credited disability by the average number of hours per week worked by or credited to the employee during the review period. This average is determined by dividing the total number of hours worked or credited during the review period by the number of weeks in the review period, excluding the period of disability.

2. If a registered Active Employee was eligible immediately prior to an Annual Review date, but because of a continuous certified disability in the review period was unable to work any hours, or worked or was credited with less than 25% of the hours required on an Annual Review, he may be credited with hours sufficient to establish his eligibility at the Annual Review.

   (a) If the disability is due partly or wholly to a job-connected illness or injury for which he receives industrial compensation (such as medical or time loss benefit payments), he may be so credited while the disability continues with hours to establish eligibility for a maximum of five consecutive years.

   (b) If the disability is not due to a job-connected illness or injury for which he receives industrial compensation, he may be so credited while the disability continues for a maximum of three consecutive years.

   If a registered Active Employee exhausts the five year or three year maximum period of eligibility, he must re-establish Welfare eligibility only by working, or being otherwise credited with (excluding any disability credits that might be available under paragraph (1) above), the hours required on an Annual or Mid-year Review.

3. A registered Active Employee desiring disability credits toward Welfare Plan eligibility must annually submit evidence satisfactory to the Trustees that certifies his disability for the period claimed and that establishes whether or not the disability is the result of a job-connected illness or injury for which industrial compensation was received. Such evidence

must include a doctor's report or a report from a health care practitioner licensed to make disability findings. The evidence may be submitted either to the Joint Port Labor Relations Committee of his Assigned Port or to the Welfare Plan Trustees. The Trustees will determine whether hours of credit toward eligibility are granted.

■ Leave of Absence and Other Credits

Credit toward the hours requirement for eligibility will be granted for the period of an authorized Leave of Absence of less than 90 days. Such credit is computed on the same basis as described above in paragraph (1) under Disability Credits. Other credits are available as described in the Welfare Agreement, including credits for employment by the parties or union, military and other leaves of absence, and travel time lost.

**NOTE: Container Freight Station (CFS) steady employees who are registered and not otherwise eligible as Active Employees, CFS and Repair and Maintenance steady employees who are not registered, nonregistered longshoremen employed to perform container maintenance and repair work under the terms of the Pacific Coast Longshore Contract Document for an employer which is a party to the Pacific Coast Longshore and Clerks' Agreement, on whose account Welfare Plan contributions are being paid as provided under the Welfare Agreement (including the employee contribution which is assessed for registered employees), and their qualified dependents have Welfare Plan eligibility effective the first of the month following three months of continuous employment, and month-to-month thereafter while so employed. They have the same benefits as Active Employees, except where Registration is expressly a requirement for a particular benefit.*

SPECIAL ELIGIBILITY RULE FOR NEWLY REGISTERED EMPLOYEES

If a newly registered employee has been registered for only a portion of the payroll period used to determine eligibility for benefits under the rules of the Annual Review or the Mid-year Review, eligibility for Welfare Plan benefits is determined as follows: the employee will be eligible for benefits for the six months commencing with the beginning of any calendar quarter if, during the two preceding payroll quarters, the employee works at least 400 hours (including casual hours). This eligibility rule applies only until such time as the employee has been registered for an entire payroll period used to determine eligibility under an Annual Review or a Mid-year Review.

LOSS OF ELIGIBILITY

Welfare Plan eligibility ends upon death or any of the following events:

Active Employees:

- at the effective date of an Annual Review if the hours requirement is not satisfied;
- severance from the industry;
- retirement — an Active Employee who loses eligibility upon severance from the industry due to retirement establishes eligibility as a Pensioner if qualified;
- loss of registration;
- as of the 91st day of an authorized Leave of Absence for any reason other than a disability illness or injury;
- commencement of an authorized Leave of Absence for military service or to work as a superintendent;
- failure of employer to make required contributions to the Welfare Plan.

NOTE: CFS and Repair and Maintenance steady employees and nonregistered longshoremen employed to perform container maintenance and repair work lose eligibility at the end of the month in which laid off.

Pensioners:

- ceases to be a Pensioner;
- failure to maintain enrollment in Medicare Part B when required.

Adult Survivor Pensioners:

- remarriage;
- failure to maintain enrollment in Medicare Part B when required.

Child Survivor Pensioners:

- termination of survivor pension;
- marriage;

- attainment of age limit for dependent coverage (see definition of Dependent Child on page 33);
- failure to maintain enrollment in Medicare Part B when required.

Surviving Dependent Spouse:

- failure to pay premiums when required;
- remarriage;
- failure to maintain enrollment in Medicare Part B when required.

Surviving Dependent Child:

- attainment of age limit for dependent coverage (see definition of Dependent Child on page 33);
- marriage;
- failure to pay premiums when required;
- failure to maintain enrollment in Medicare Part B when required.

Dependent Spouse:

- enrollment cancelled by person through whom enrolled;
- loss of eligibility by person through whom enrolled;
- final dissolution of marriage;
- failure to maintain enrollment in Medicare Part B when required.

Dependent Child:

- enrollment cancelled by person through whom enrolled;
- loss of eligibility by person through whom enrolled;
- marriage;
- attainment of age limit for dependent coverage (see definition of Dependent Child on page 33);

- end of dependency upon person through whom enrolled;
- failure to maintain enrollment in Medicare Part B when required.

Surviving ERISA Spouse:

- remarriage;
- failure to maintain enrollment in Medicare Part B when required.

Welfare Plan health care benefits are not provided to an otherwise eligible person who is confined in a public institution (other than a Veterans Administration or other military hospital) where room, board, and medical care are provided.

Upon loss of eligibility no person may qualify to receive Welfare Plan benefits, except as provided under "COBRA" below.

■ Re-establishing Eligibility

If an eligible Active Employee is granted a Leave of Absence that terminates his Welfare Plan eligibility, and returns from his Leave during a period for which he had established eligibility, his eligibility will be re-established immediately.

If a Leave of Absence is granted to an eligible Active Employee to work as a superintendent, eligibility will be re-established as of the date the employee returns from his Leave and will continue until he first has an opportunity to establish eligibility by meeting the hours requirement, provided he returns to covered employment within 30 days following the end of his Leave of Absence.

An Active Employee who exhausts the five year or three year maximum period of eligibility on account of continuous disability credits, as described on pages 12 - 14, will re-establish eligibility only by working, or being otherwise credited with (except for disability credits), hours sufficient to satisfy the hours requirement.

Persons who lose Welfare Plan eligibility because of failure to maintain enrollment in Medicare Part B when required will re-establish eligibility upon such enrollment.

■ COBRA - Continuation of Medical Coverage

Under the federal COBRA law, the Welfare Plan offers eligible employees and their dependents the opportunity for a temporary extension of certain medical benefits under the Welfare Plan at group costs (plus an administrative surcharge of 2%), following the occurrence of certain qualifying events, where coverage would otherwise end. The Plan Office will provide you with a notice explaining your COBRA rights under the Welfare Plan. For a dependent to be eligible for COBRA continuation coverage, the employee, Pensioner, or his spouse or dependent must inform the Plan Office within 60 days of a divorce, legal separation, or a loss of dependent status under the Plan. Forms that may be used for this purpose are available at the Locals and the Plan Office. When the Plan Office receives confirmation that you or your dependents are entitled to purchase continuation coverage, election forms will be provided. If continuation coverage is not elected, medical benefits will end as provided in the Welfare Plan.

Note: Although the Trustees intend to provide eligibility for the lifetimes of participants and beneficiaries subject to the limitations set forth above and elsewhere in this Summary Plan Description, continued eligibility is subject always to the provisions of the Welfare Agreement and to ILWU-PMA collective bargaining.

ILWU-PMA WELFARE PLAN BENEFIT PROGRAMS

Detailed descriptions of benefits and services provided under each ILWU-PMA Welfare Plan benefit program are available in separate Supplemental Summary Plan Description booklets and are incorporated by reference herein. The booklets describe how and where to obtain benefits, any additional requirements other than Welfare Plan eligibility that must be met to be entitled to a particular benefit, whether dependent coverage is provided and, if so, the qualifications, and information about claims and review procedures. To the extent a Supplemental Summary Plan Description is inconsistent with this booklet, the provisions of the Welfare Plan Agreement will govern.

Copies of Supplemental Summary Plan Description booklets are supplied to ILWU Locals and are available without cost upon request at the Plan office.

The Plan does not provide any person with benefits (other than Death, Accidental Death and Accidental Dismemberment benefits) for conditions that are covered by the Longshoremen's and Harbor Workers' Compensation Act and/or a state workers' compensation or similar act that provides compensation for industrial injury.

The following chart is for reference:

Type of Benefit	***Persons with Welfare Plan eligibility for whom benefit is provided***
Hospital-Medical-Surgical **Prescription Drug** **Vision Care** **Hearing Aid** **Dental**	For active Longshoremen, Ship Clerks, Walking Bosses/Foremen, Watchmen, Pensioners under the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan, Survivor Pensioners, Surviving Dependents, Surviving ERISA Spouses, eligible dependents.

Type of Benefit	*Persons with Welfare Plan eligibility for whom benefit is provided*
Death, Accidental Death & Accidental Dismemberment	Program I - For active Longshoremen, Ship Clerks, Walking Bosses/ Foremen, Watchmen. Program II - For Pensioners (other than Survivor Pensioners) under the ILWU-PMA Pension Plan or ILWU-PMA Watchmen Pension Plan, certain Social Security retirees.
CSDI Supplementation	For certain active Longshoremen, Ship Clerks, Walking Bosses/ Foremen, Watchmen in California.
Weekly Indemnity	For active Longshoremen, Ship Clerks, Walking Bosses/ Foremen in Oregon and Washington.
Non-Industrial Disability Supplement	For active Longshoremen, Ship Clerks, Walking Bosses/ Foremen and Watchmen who receive CSDI in California or Weekly Indemnity in Oregon and Washington.
Alcoholism/Drug Recovery Program	For active and retired Longshoremen, Ship Clerks, Walking Bosses/ Foremen, Watchmen.
Social Security Supplementation	For certain Longshoremen, Ship Clerks, Walking Bosses/ Foremen who are Pensioners under the ILWU-PMA Pension Plan.

HEALTH CARE PROGRAMS — ANNUAL CHOICE

The health care programs of the Welfare Plan provide hospital-medical-surgical benefits, prescription drugs, vision care, and dental care. Persons with eligibility (including their qualified dependents) whose Assigned Port is a Choice Port or Choice Area, have most health care programs provided by either an HMO or through a primarily self-funded arrangement, and may annually make a choice between the HMO and the self-funded and insured programs. Persons with eligibility whose Assigned Port is a Non-Choice Port or Non-Choice Area have most coverage available primarily through a self-funded arrangement. All persons with eligibility, and their dependents, who do not live in port areas have Non-Choice Port coverage.

CLAIMS REVIEW PROCEDURES

Any Welfare Plan claim which is denied or partly denied will be reviewed upon request of the claimant. Included are claims for Welfare Plan eligibility, for disability and other credits toward the hours requirements for Plan eligibility, and for any type of benefit under the Welfare Plan.

■ Claim Denial

If a claim is denied or partly denied, notification will be given in writing. Such notification will be written in understandable language, and will state:

(a) Specific reasons for denial of the claim,

(b) Specific reference to provisions of the Welfare Agreement or to contract provisions upon which the denial is based,

(c) A description, if appropriate, of additional information or material necessary for the claimant to perfect the claim, and the reason such information or material is required, and

(d) An explanation of how, where, and when the claimant may process a review of the denial.

Notice of the denial of a claim must be given within 90 days of the date it is submitted, or within 180 days if notification of the extension is given to the claimant. A claim that is not acted upon within the time prescribed may be deemed by the claimant to have been denied.

■ Request for Claim Review

Within 60 days after a claim has been denied, or deemed denied, the claimant or the claimant's representative may make a written request for a full and fair review. Pertinent documents relating to the denial may be reviewed, and issues and comments may be submitted in writing.

■ Where to Submit Requests for Review

Requests for review of claims relating to:

- Welfare Plan eligibility
- Disability credits towards eligibility

should be submitted to:

ILWU-PMA Welfare Plan
1188 Franklin Street - 3rd Floor
San Francisco, CA 94109

Requests for review of claims relating to individual benefit programs should be submitted either to the Welfare Plan or directly to the insurance carrier, provider of care, or third party administrator, as directed in the Supplemental Summary Plan Description booklet that describes the particular benefit.

Any request for a claim review may also be submitted to the Welfare Plan Trustees, who will either provide the review or refer the request to the appropriate insurance carrier, provider of care, or third party administrator, and will make certain that the claimant receives a full and fair review. The Welfare Plan provides the Trustees (or their designees) with the authority and discretion to make the final determination in claim reviews. Such authority and discretion includes the power to interpret, construe, and apply the terms of the Agreement and to decide all issues of fact arising thereunder, including, without limitation, the power to determine whether eligibility to participate in the Plan or to qualify for a benefit has been established in accordance with the Agreement and the amount of benefits (if any) that may have become payable.

■ Decision on Review

A decision on the review of a claim will be made within 60 days after receipt of the request for the review, unless an extension of time for processing a review is required, in which case the

claimant will be notified and a decision will be made within 120 days of receipt of the request for review. The decision will be communicated in writing, and in understandable language. It will include specific references to Welfare Agreement or contract or insurance policy provisions upon which the decision is based. In cases in which the review is conducted by the Welfare Plan Trustees, the decision will indicate whether or not the claim is subject to arbitration and, if so, how to proceed to arbitration.

■ Judicial Review

Before a claimant under the Welfare Plan files suit in a court of law against the Trustees or an insurance carrier or provider of care in connection with a Welfare Plan claim, Plan provisions require that the claimant obtain a determination by the Trustees as to whether the benefit claimed is provided under the Welfare Plan and, if so, the identity of the provider of the benefit.

Plan provisions also require that Welfare Plan Claims Review Procedures, including arbitration where provided, be followed by Plan claimants. Certain questions are subject to arbitration if a claimant is dissatisfied with the decision upon review of a claim. Such questions are those pertaining to basic Plan eligibility and to whether a benefit claimed is provided under the Welfare Plan. A claimant may file suit in a federal or state court if he is improperly denied any right or remedy to which he is entitled under the Welfare Plan Claims Review Procedures.

SUBROGATION, REIMBURSEMENT, AND ASSIGNMENT

■ Subrogation and Reimbursement

Any person who receives benefits or is eligible to receive benefits under the Welfare Plan must agree in writing to reimburse the Plan to the extent any benefits payments are recovered from the proceeds of any judgment or settlement on account of any illness, injury, or condition for which an employer or other third party (or their respective insurers) may be liable. In addition, any person eligible for benefits under the Plan must (i) notify the Trustees of the Plan within thirty (30) days, after making a claim against an employer or other third party (or their respective insurers) relating to an incident leading to benefits, of the fact and nature of such claim, (ii) furnish any information or assistance and execute any documents that the Trustees require, and (iii) take no action that may prejudice or interfere with such rights.

Whether or not the preceding requirements are satisfied, the Trustees shall (1) be automatically assigned such person's right of action against the employer or other third party (or their respective insurers); (2) have the right to intervene at any time in any action brought against an employer or other third party (or their respective insurers) to recover benefits that have been paid; and (3) have an automatic lien upon any recovery to the extent of benefits paid.

The information in this section generally applies to any no-fault insurance recoveries and all proceedings and actions, including but not limited to proceedings under the Longshore and Harbor Workers' Compensation Act, other workers' compensation acts, and actions for negligence, medical malpractice, products liability, and other torts or wrongful acts.

■ Assignment

Generally, Welfare Plan benefits or the rights to receive such benefits may not be assigned to any third party other than doctors or other providers of care. However, ERISA provides that in the case of persons with coverage under a State Medicaid program, automatic assignment of benefits to State Medicaid agencies is enforceable against the Plan.

GENERAL INFORMATION

1. The Employer Identification Number issued to the ILWU-PMA Welfare Plan Trustees by the Internal Revenue Service is 94-6068578. The Plan Number assigned by the Trustees is 501. The Plan's fiscal year is July 1 - June 30.

2. The Trustees are the administrator of the Plan. The Trustees may designate employer and union Trustees having equal representation as a Benefit Subcommittee, which shall be the administrator of the Plan. The business address and business telephone number of the Plan administrator are those shown in this booklet for the ILWU-PMA Welfare Plan.

3. Service of legal process may be made upon a Plan Trustee or the administrator of the Plan. The person designated by the Plan as agent for the service of legal process is:

   Executive Director
   ILWU-PMA Welfare Plan
   1188 Franklin Street - 3rd Floor
   San Francisco, CA 94109

4. It is the Trustees' policy not to release information about a Plan participant or beneficiary to anyone without either written authorization by the participant or beneficiary or a court-ordered subpoena. A subpoena of records should be addressed to the "Custodian of Records" of the ILWU-PMA Welfare Plan.

5. The programs of the ILWU-PMA Welfare Plan are financed by contributions of employers and registered employees. Employers contribute to the Welfare Plan the amount in addition to employee contributions that is required to finance the programs and administrative costs of the Welfare Plan. Effective September 11, 1993, each registered employee contributes 1.3% of his wages, excluding payments received under the ILWU-PMA Pay Guarantee Plans and the Welfare Plan. The employee contribution rate to the Welfare Plan

is subject to change by agreement of the Trustees. If an employee is required to contribute to the California State Disability Insurance program, his contribution to the Welfare Plan is reduced in the amount of his payment to that program. Pacific Maritime Association has been designated by the Trustees as the contribution collecting agent.

6. Assets of the Welfare Plan are accumulated in the ILWU-PMA Welfare Fund and benefits are provided either under contracts or policies of insurance or by direct payment by the Welfare Plan. The Supplemental Summary Plan Description booklets identify the providers of benefits.

7. While this booklet and the Supplemental Summary Plan Description booklets set forth the terms and conditions of the contracts and policies of insurance between the Welfare Plan Trustees and the insurance carriers and providers of care, the provisions of such contracts and policies cannot be modified by the summaries set forth in this booklet and the Supplemental booklets. The terms and conditions of such contracts and policies of insurance, where applicable, control and limit availability of benefits under the Plan.

8. The Plan maintains a register which shows the names of persons currently serving in the office of Trustees, as a member of the Benefit Subcommittee, and as the Plan Executive Director. Beneficiaries and participants may inspect the register, and upon written request may receive a copy of the names and business addresses of persons currently serving in any of the above mentioned capacities.

9. It is the Welfare Plan Trustees' policy to have the Plan office give answers in writing to all questions about the Plan. By putting questions in writing, a participant or beneficiary will be able to receive a written response to the exact question in mind. A participant or beneficiary may rely upon written answers from the Plan office. Conversely, a participant or beneficiary should not rely on any oral answers to questions about the Plan, from whatever source the oral information is received. A participant or beneficiary should never assume that he can rely upon any statement as to his employment history, from whatever source, that he has the least reason to know to be inaccurate.

10. Participants and beneficiaries of the ILWU-PMA Welfare Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants and beneficiaries shall be entitled to:

    (a) Examine, without charge, at the Plan office and at other locations designated by the Trustees all Plan documents, including contracts and policies of insurance with providers of care, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.

    (b) Obtain copies of all Plan documents and other Plan information, including information as to whether a particular employer is a contributing employer, upon written request to the Plan office. The Plan administrator may make a reasonable charge for copies.

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

In addition to creating rights for Plan participants and beneficiaries, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one,

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

If your claim for a Welfare Plan benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim, as outlined in the Claims Review Procedures section beginning on page 24. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

Claimants may file suits in a state or federal court as referred to on page 26 of the Claims Review Procedures section.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan office. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

SOME HELPFUL DEFINITIONS

Some of the terms used in this booklet are of special importance in understanding eligibility provisions and benefits described in its pages. The following definitions are based upon provisions of the ILWU-PMA Welfare Agreement.

Assigned Port: The port at which an Active Employee is registered, or such other port as a Joint Port Labor Relations Committee may determine to be his port of regular employment, or if he so elects, the port at which a registered Active Employee has been granted the status of being an official visitor by a Joint Port Labor Relations Committee. Pensioners and survivors shall have an Assigned Port determined by the Trustees on the basis of residence. An eligible Active Employee whose registration is transferred to another port at the convenience of the industry and who does not change his place of residence may elect to retain the coverage of the port from which he is transferred.

Choice Port or Choice Area: A port or area for which the Trustees contract with a group practice health plan (HMO) serving such port or area with hospital-medical-surgical and other health care benefits and also provide insured and self-funded coverage for the same types of benefits. An eligible person whose Assigned Port is a Choice Port or Choice Area may annually choose for himself and his dependents between the HMO, and the insured and self-funded coverage.

Dependent Child: A person who (1) relies upon an Active Employee, Pensioner, or Dependent Spouse for the majority of his or her support (such as food, clothing, housing, and medical care), (2) who is identified by the Active Employee or Pensioner on the form provided by the Trustees for the enrollment of dependents (which form has been filed with the Trustees), (3) who is unmarried, (4) who is within one of the following classes: (a) a natural child of an Active Employee or Pensioner, (b) a legally adopted child of an Active Employee or Pensioner, (c) a stepchild or

foster child of an Active Employee or Pensioner, or (d) a child who has or had a parent/child relationship with an Active Employee or Pensioner if such child's natural parent is not in fact supporting such child, and (5) who either (i) has not attained 19 years of age or, if over 19, is recognized without additional cost to the Trustees as a Dependent Child by any of the insurance carriers or providers of care utilized by the Trustees to provide benefits, or (ii) has not attained 23 years of age but is a full-time student engaged in a course of study at a school recognized by the Trustees, or (iii) is, and continues to be, upon attaining the age limit set forth above, mentally or physically incapacitated so as to be incapable of self-sustaining employment. See note below.*

Dependent Spouse: A person who is married to an Active Employee or Pensioner and who is so identified on the form provided by the Trustees for the enrollment of dependents that has most recently been filed by the Active Employee or Pensioner with the Trustees. A person will be considered married if such marriage is valid under the laws of the state in which it was contracted.

Leave of Absence: A period during which an employee is granted permission by a Joint Port Labor Relations Committee to be absent from work or from availability for work.

Major Port: The Los Angeles/Long Beach Harbor Area, the San Francisco Bay Area, the Portland/Vancouver Area, the Seattle Area, and any other port that is not classified as a Minor Port.

Minor Port: A port not named above as a Major Port, and for which the Annual Review by the

**NOTE: Certain children for whom medical coverage is required to be provided under a Qualified Medical Child Support Order may not satisfy the definition of a Dependent Child in its entirety, but are required to satisfy the age and marital status requirements.*

Trustees shows the following: that of the registered employees assigned to the port who worked and/or received PGP credits for at least 100 hours during the review period, 25% or more worked or were so credited with less than 800 hours (or that, at the Mid-year Review, of the registered employees assigned to the port who worked and/or received PGP credits for at least 50 hours during the review period, 25% or more worked or were so credited with less than 400 hours).

Non-Choice Port or Non-Choice Area: Any port that is not classified as a Choice Port, and any area that is not a Choice Area.

Pay Guarantee Plans (PGP): The ILWU-PMA Pay Guarantee Plan and the ILWU-PMA Walking Bosses/Foremen Pay Guarantee Plan.

Payroll Year: The year that PMA establishes annually for payroll accounting purposes, which may not exactly coincide with the calendar year.

Registration: The status established under any of the procedures jointly administered by the Union or its Locals and PMA for selecting employees who are deemed to be permanently attached to the industry.

WIDOWS' INDEPENDENT LIVING SUBSIDY PROGRAM

The ILWU-PMA Widows' Independent Living Subsidy Program provides eligible widows with the following types of benefits: Independent Living Cash Subsidy benefits and Medicare Supplement (health care) benefits. The widows who are eligible under this Program are not eligible for the ILWU-PMA Welfare Plan benefits described elsewhere in this booklet. An eligible widow under this Program is the widow of a Longshoreman, Ship Clerk or Walking Boss/Foreman who:

- died prior to July 1, 1964 while a pensioner under the ILWU-PMA Pension Plan, or
- died prior to July 1, 1975 with a minimum of 13 qualifying years of service, was not a pensioner, had ILWU-PMA Welfare Plan eligibility on the date of his death, and whose widow was born on or before July 1, 1916 and is receiving Social Security benefits.

Widows' Program provisions are set forth in the ILWU-PMA Supplementary Agreement to Establish the ILWU-PMA Widows' Independent Living Subsidy Program, as amended. A separate booklet, called "A Supplemental Summary Plan Description of the ILWU-PMA Widows' Independent Living Subsidy Program", describes the Program's benefits and eligibility requirements in greater detail.

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

AN ILWU-PMA WELFARE PLAN SUMMARY PLAN DESCRIPTION INSERT

July 2005

1.Page 15, Special Eligibility Rule for Newly Registered Employees
After July 1, 2002, new registrants and their dependents in ports with HMO coverage will, on the first of the month following registration (with no requirement for 400 hours of work for initial eligibility for coverage), be covered by the HMO programs for the first eighteen (18) months of registration. After 18 months of registration the member will have a choice of HMO or Coastwise Indemnity Plan coverage and normal Welfare Plan eligibility requirements shall apply. The Trustees of the Welfare Plan may provide on an "exception basis" that a person eligible for HMO coverage under this provision may be provided limited coverage under the Coastwise Indemnity Plan specific to any serious health condition for which they are receiving treatment when Welfare Plan coverage begins.

After July 1, 2002, new registrants and their dependents in ports without HMO coverage will, on the first of the month following registration (with no requirement for 400 hours of work for initial eligibility for coverage), be covered by the Coastwise Indemnity Plan for the first eighteen (18) months of registration and shall thereafter be subject to the Welfare Plan's normal eligibility requirements for continuation of coverage under the Coastwise Indemnity Plan.

2. Page 22, Alcoholism/Drug Recovery Program, The Trustees of the ILWU-PMA Welfare Plan have implemented coordination of the chemical dependency recovery program benefit under the Welfare Plan, effective July 1, 1995. All eligible members and their dependents will be covered for chemical dependency recovery programs under the industry's Alcoholism/Drug Recovery Program (ADRP). ADRP benefits and limitations will be the same for dependents as for employees.

3. Page 23, Health Care Programs - Choice Periods, The health care programs of the Welfare Plan provide hospital-medical-surgical benefits, prescription drug, vision care and dental care. Persons with eligibility (including their qualified dependents) who live in an area where a qualified HMO (group practice) is available have most health care provided by either an HMO or through a primarily self-funded arrangement, and may choose between the two programs. Plans may be changed during a choice period each year, in May. In addition to the May choice period, members may change their health plan once at any time during the Plan year (July 1 - June 30). All persons with eligibility and their dependents who do not live in areas where a qualified HMO is available have their health care provided through a primarily self-funded arrangement.

4. Page 24 and 25, Claims Review Procedures
Any Welfare Plan claim which is denied or partly denied will be reviewed upon request of the claimant. Included are claims for Welfare Plan eligibility, for disability and other credits toward the hours requirements for Plan eligibility, and for any type of benefit under the Welfare Plan. 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, 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 Social Security Supplementation Benefit, 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 medical treatment (e.g., are considered experimental), the claimant has the right to request a free copy of the scientific or clinical judgment 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 ILWU-PMA Welfare Plan 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 ILWU-PMA Welfare Plan expects to render a decision on the claim. If an extension is required because the claimant failed to submit sufficient information to enable the ILWU-PMA Welfare Plan 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 ILWU-PMA Welfare Plan 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.

Request for Claim Review by Trustees of the ILWU-PMA Welfare Plan
Within 180 days after notice that a claim has been denied by ILWU-PMA Welfare Plan, 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

(OVER)

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 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.

5. Page 28, Assignment, **Under provisions of the Welfare Plan, Welfare Plan benefits are not subject to assignment by a participant, beneficiary or any other person except the Trustees, and any attempt to do so shall be void.** However, ERISA provides that in the case of persons with coverage under a State Medicaid program, automatic assignment of benefits to State Medicaid agencies is enforceable against the Plan. Where benefits are paid directly to a doctor, hospital or other provider of care (other than to a State Medicaid agency), such direct payments are provided at the discretion of the Trustees as a convenience to Plan participants and do not imply an enforceable assignment of Welfare Plan benefits or the right to receive such benefits.

6. Page 36, Widows' Independent Living Subsidy Program, The ILWU and PMA have agreed to adopt a dental benefit for the Widows' Independent Living Subsidy Program, effective January 1, 1996. A separate Group Dental Program Evidence of Coverage and Summary Plan Description booklet describes the widows' dental benefit in detail.

7. ILWU-PMA WELFARE PLAN TRUSTEES

Union Trustees	Employer Trustees
Robert M. McEllrath Vice President ILWU 1188 Franklin Street San Francisco, CA 94109	Ronald J. Forest Sr. Vice President Matson Navigation Company 555 12th Street Oakland, CA 94607-4046
Ray Ortiz, Jr. Coast Committeeman ILWU 1188 Franklin Street San Francisco, CA 94109	Robert L. Stephens Vice President – Labor Relations American President Lines, Ltd. 1111 Broadway, 6th Floor Oakland, CA 94607
Joseph Wenzl Coast Committeeman ILWU 1188 Franklin Street San Francisco, CA 94109	Michael H. Wechsler Sr. Vice President & CFO PMA P. O. Box 7861 San Francisco, CA 94120-7861