WELFARE FUND BENEFITS

HRSA-ILA WELFARE FUND
SUMMARY PLAN DESCRIPTION

The HRSA-ILA Welfare Fund ("The Plan") provides disability benefits and life insurance benefits. The short term disability benefits are administered by Amalgamated Medical Care Management, Inc.

The life insurance benefits provided by the Plan are self-insured. 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 Trust Agreement for the Plan which controls your entitlement to benefits. You have a right to see or obtain a copy of 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 Trust Agreement 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.**

NOTE: Your other health care benefits are provided under the MILA National Health Care Trust Fund. Claims administration services are provided for MILA by CIGNA Health Care, CVS Caremark, EyeMed and Aetna. For a description of eligibility and benefits, refer to the Summary Plan Description forwarded to you by MILA.

ELIGIBILITY, ENROLLMENT, & COVERAGE

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 an ILA Local or the HRSA-ILA covered by a Participation Agreement

  and

- You 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 coverage for Short Term Disability, Life and Accidental Death and Dismemberment Insurance will begin on October 1 following the contract year you meet the eligibility requirements.

Retiree

When you retire, you are eligible for basic life insurance benefits under the HRSA-ILA Welfare Plan if you meet the following criteria. You must also meet these criteria to be considered for MILA benefits as a pensioner.

- 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 700 hours in 5 of the 7 above contract years

  or

- **20+ Years of Service:** Employees with at least twenty years of service must have worked or received credit for a minimum of 700 hours in 4 of the 7 above contract years

NOTE: A year of service is a contract year during which you work or receive credit for at least 700 hours in the industry. 10 years of service is the minimum required to qualify for Welfare Fund benefits as a retiree.

Dependents of Deceased Employees or Deceased Retirees

Eligibility for the surviving spouse will end upon the remarriage or death of the surviving spouse.

NOTE: A surviving spouse must have been married to and residing with the deceased retiree to be eligible for Plan benefits.

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 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 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. The amount of credits that you receive is based upon the level of benefits you qualified for in the immediate prior year.

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.

IMPORTANT NOTES:

- **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 workers' compensation disability benefits or for lump sum settlements.**

When Coverage Ends

Participant Coverage

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

- Short Term Disability, Life and Accidental Death & Dismemberment Insurance ends on September 30 if you fail to earn coverage as described in the Eligibility Information section of this booklet;
- 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 authorize your doctor to submit for review information about your medical condition; 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 for returning to work, 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.

Spouse Coverage

Coverage for a spouse ends at the date the spouse and the participant or retiree are no longer residing together.

Surviving Spouse Coverage

Coverage for a surviving spouse ends upon re-marriage.

Subrogation and Reimbursement

If the Welfare Fund pays short term disability payments for a participant, 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, and 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 any benefits that are paid by the Welfare Fund that arise out of any injury or illness. 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 short term disability benefits for you and your fellow Participants.

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 for payment approval by Amalgamated Medical Care Management, Inc.

Weekly Benefit

The level of benefit you receive is based upon your years of service and your prior-year work hours. A year of service is a contract year in which you work or receive credit for at least 700 hours. If you qualify for benefits, however, you may not receive more than 2/3^{rds} of your average weekly work wage calculated from 365 days worked prior to your accident or injury. **You must be eligible for the benefit at the time of your illness or injury for benefits to be payable.**

Years of Service	Hours Required			
	700-999	1000-1399	1400-1999	2000+
15+	$175	$300	$500	$650
1-14	$150	$250	$350	$450

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.

Maximum Benefit Period

Benefits will be payable up to the maximum benefit period during any one continuous period of total disability as follows:

52 Weeks: Non-work related illness or injury
26 Weeks: Work-related illness or injury, subject to repayment

Short term disability benefits for a work-related illness or injury may be extended, at the discretion of the Board of Trustees, for up to 26 weeks, if you have been unable to receive necessary medical treatment that would enable you to return to work and such delay in treatment was the result of a health care crisis or natural event (such as a hurricane). The Board of Trustees may request documentation that the delay was a direct result of the health care crisis or natural event.

When do benefits begin? The coverage will begin on the earliest of the following dates:

- the first day of disability due to accident or pregnancy;
- 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 calendar 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.

Termination of Benefits: The maximum benefit period for non-work related illness or injury is 52 weeks. Work related illnesses or injuries (subject to repayment) have a maximum benefit period of 26 weeks. Disability benefits paid for substance abuse have a maximum benefit period of 26 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 20). 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.

IMPORTANT NOTE: The benefits for any participant who incurs a second or third violation of the Industry's Drug and Alcohol policy, and is suspended or terminated from employment in the industry, shall be automatically terminated and the participant will lose short term disability coverage as of the date of such suspension or termination.

Successive Periods of Disability

- If you are an eligible participant and return to work for LESS than 7 consecutive work days, any recurrence of the same or related cause of disability is considered to be the same period of disability and subject to the same Maximum Benefit Period. In this instance, no additional elimination period will apply. If the successive disability is un-related or for a different cause than the prior period, then it is treated as a new disability.
- If you are an eligible participant and return to work for 7 consecutive work days or more, any recurrence of the same or related cause of disability will be treated as a new disability, with respect to when do benefits begin, Elimination Period, and the Maximum Benefit Period.
- Successive Periods of Disability due to injuries received in one accident are considered as one period, regardless of a return to work. The Board will determine, in its sole discretion, whether multiple injuries or periods of disability are related to a single accident.

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 (unless determined to be medically necessary)
  - 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.
- The Plan will not pay a benefit for any period of disability during which you are incarcerated.
- The Plan will not cover a disability when you have been terminated from the industry for a contract violation.
- 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 1 (800) 794-7882.

NOTE: 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

To file for benefits you, and your doctor, must complete a claim form and send it to Amalgamated Medical Care Management. Claim forms are available at the Fund office or online at www.hrsa-ila.com. To check on your claim status, call Amalgamated Medical Care Management, Inc. at (866) 975-4090.

Submitting a Claim

You must apply for a 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.

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 Virginia 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 do not include an elective cesarean 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 January 1, 2011, the Member Assistance Program is administered by CIGNA.

"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 statues 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.

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.

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.

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.

Benefits paid for the treatment of substance abuse will continue for up to twenty-six weeks 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.

If you are terminated for a contract violation, your benefit will stop.

How is the benefit figured?

Based upon your longevity and your hours during the previous Contract Year, you will qualify for one of the weekly benefit levels shown on page 17; 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 your employment is suspended or terminated for a second or third violation of the Industry's Drug and Alcohol Policy;
- 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.

Filing a Claim for Short Term Disability Benefits

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; or

If you are injured at work you must notify your employer. 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. Claim forms are available at the Fund office and at www.hrsa-ila.com. This form authorizes the release of medical information we need in order to process any benefit for which you may be eligible.
- If your inability to work is a result of substance abuse, call the Member Assistance Program at 1 (800) 794-7882 for referral to a substance abuse professional.
- Fax or mail a copy of the completed authorization to Amalgamated Medical Care Management, Inc.

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

Fraud Warning for HRSA-ILA Participants

Making a fraudulent claim for benefits is a violation of the collective bargaining agreement and 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 is needed to complete your claim. Claim forms are available at the Fund office and www.hrsa-ila.com. You will need the following information for the claim form:

- policyholder's name: HRSA-ILA Welfare Fund.
- 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;
- 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;
- and 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. A determination of your eligibility for disability benefits will not begin until you have completed a promissory note.

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.

NOTE: 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 Amalgamated Medical Care Management, Inc. Authorization Form to be submitted to your health care provider is located in the Personal Section of your Summary Plan Description.

HRSA-ILA Welfare Fund Claims administered by:

HRSA-ILA c/o Amalgamated Medical Care Management, Inc.
PO Box 5453
White Plains, NY 10602-5453
Toll Free: (866) 975-4090
Fax: (914) 367-4114
Web: www.amalgamatedbenefits.com

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 below. If you have any questions about what to do, you should contact us directly.

Claim 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 it is determined 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
- describe your right to request access to and copies of all relevant documents without charge;
- state your right to bring an action under Section 502(a) of ERISA; 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 90 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 automatically receive a copy of any new or additional evidence considered by the Trustees, any new or additional rationale for a denial, and reasonable opportunity to respond to new information by presenting written evidence and testimony. You will have access to all relevant documents as defined by applicable US 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 an action under Section 502(a) of ERISA;
- 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 US 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.

NOTE: 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 short term disability benefits you received.

Subrogation and Reimbursement

If the Welfare Fund pays short term disability payments to 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 Worker's 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.

LIFE INSURANCE

Introduction

The HRSA-ILA Welfare Fund provides life insurance described on the following pages for employees covered under the life insurance program (the "Plan"). 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.

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.

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 contract 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 $50,000. 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 $15,000 of coverage.

Important Note: If a participant dies after submitting a retirement application, but before the Pension application is approved by the Board of Trustees, the participant's life insurance benefit will be reduced to the retired employee level.

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 provided by and filed with the Fund Office. 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 upon receipt of a certified copy of the Death Certificate, and a copy of the Beneficiary Form provided by and filed with the Fund Office. To be considered for payment, a claim must be filed within one year after the death of the insured.

Beneficiary

Be sure you have named the person who is to be your beneficiary on a Beneficiary Form with HRSA-ILA. You may select or change your beneficiary by:

- completing the required Beneficiary Form on our website at https://www.hrsa-ila.com; or
- calling HRSA-ILA to request a Beneficiary Form, (757) 457-7090, 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.

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 provided by and filed with the Fund Office.

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 26).	
*"Member" means a hand, foot or eye.	

Exclusions

This policy does 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.

MEDICARE "PART B" PREMIUM REIMBURSEMENT

Medicare "Part B" Premium Reimbursement

The following information on the Medicare Part B Premium Reimbursement applies to participants whose Medicare Part B effective date is not later than September 30, 2010 and who have applied for premium reimbursement. No Medicare Part B Premium reimbursements will be made for a period before application to the Fund.

A retiree who qualifies for MILA and HRSA-ILA Welfare benefits and who is covered by Medicare for Part B will be reimbursed for the Medicare Part B premium provided an annual proof of the Part B coverage is submitted to HRSA-ILA upon request. The eligible spouse of a retiree or a deceased employee who is receiving benefits from the HRSA-ILA Pension Plan may also receive the premium reimbursement subject to the above conditions.

Premium reimbursement will begin on the date of Part B enrollment provided you submit a copy of the proof of enrollment within 90 days of the beginning of coverage. Where the proof of enrollment is received after 90 days, reimbursement will be effective the month received and will not be retroactive.

Premium reimbursement will also end if you fail to provide proof of Medicare Part B coverage to the Fund upon request. In January the Fund will request that you send a copy of the notice sent by the Social Security Administration in December advising of your benefits for the next coming calendar year.

Payments will be made by direct deposit only and will be distributed to the member or surviving spouse on a quarterly basis on or about January 10th, April 10th, July 10th and October 10th.

If you qualify for Medicaid, you are no longer required to pay the Medicare Part B premium and you will no longer be entitled to premium reimbursement. It is your responsibility to notify the Plan when you qualify for Medicaid. You will be required to reimburse the Plan for any payments that you received to which you were not entitled.

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:

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.

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 include such activities as:

- 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;
- 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:

- 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 a 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.

With regards to 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 31).

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 **May 31, 2009**. 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 the Administrator 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 Boulevard
Norfolk, VA 23505-1458
Phone: (757) 457-7090 Fax: (757) 423-1205

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 Boulevard
Norfolk, VA 23505-1458
Phone Number: (757) 457-7090
https://www.hrsa-ila.com

AGENT FOR SERVICE OF LEGAL PROCESS

The Board of Trustees
HRSA-ILA Welfare Fund
1355 International Terminal Boulevard
Norfolk, VA 23505-1458

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.