DELTAPREMIER*
Managed Fee-for-Service Program

For

Employees

of

ILWU-PMA WELFARE PLAN, LONGSHORE DENTAL PROGRAMS

Group Dental Program Evidence of Coverage and Summary Plan Description

Group Nos.

1 & 1713

Provided by:
STATE DENTAL SERVICE

PLANS OF:
CALIFORNIA
OREGON
WASHINGTON

PLAN SPONSOR:
ILWU-PMA Welfare Plan,
Longshore Dental Programs

EMPLOYER IDENTIFICATION NUMBER:
94-6068578

PLAN NUMBER:
501

NAME AND ADDRESS OF PLAN ADMINISTRATOR:
Trustees of ILWU-PMA Welfare Plan
1188 Franklin Street - 3rd Floor
San Francisco, CA 94109

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS:
Executive Director
ILWU-PMA Welfare Plan
1188 Franklin Street - 3rd Floor
San Francisco, CA 94109

(Service of legal process may also be made on the Plan Administrator at the address shown above)

PLAN FISCAL YEAR ENDS:
June 30

NAME AND ADDRESS OF EMPLOYER:
ILWU-PMA Welfare Plan
Longshore Dental Programs
1188 Franklin Street - 3rd Floor
San Francisco, CA 94109

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

A SUMMARY PLAN DESCRIPTION OF THE GROUP DENTAL PROGRAM FOR ELIGIBLE EMPLOYEES OF ILWU-PMA WELFARE PLAN, LONGSHORE DENTAL PROGRAMS

This booklet is a Summary Plan Description of the Group Dental Program ("Program") and has been prepared for participants of the ILWU-PMA Welfare Plan.

Dental benefits are provided by the ILWU-PMA Welfare Plan for active and retired longshoremen, ship clerks, walking bosses/ foremen, watchmen, and their qualified dependents. Qualified surviving spouses of active and retired employees are also covered.

This Program has been established and is maintained and administered in accordance with the provisions of Group Dental Agreements between the Trustees of the ILWU-PMA Welfare Plan and the following State Dental Service Plans:

DELTA DENTAL PLAN OF CALIFORNIA
P. O. Box 7736
San Francisco, California 94120

For claims, eligibility and benefit inquiries, call Delta's Customer and Member Service Department Toll-Free at:
(888) DELTA CS
(888) 335-8227

Or contact us on the Internet at:
E-mail: cms@delta.org
Web site: www.deltadentalca.org

and

OREGON DENTAL SERVICE
315 SW Fifth Avenue, Suite #100
Portland, Oregon 97204
Toll Free Number: (800) 452-1058

and

WASHINGTON DENTAL SERVICE
P.O. Box 75983
Seattle, Washington 98125
Toll free Number: (800) 554-1907

IMPORTANT

This booklet is subject to the provisions of the Group Dental Contract and cannot modify or affect the Group Dental Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

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ILWU-PMA DENTAL PROGRAMS GENERAL INFORMATION

(applicable to both Adult and Children's Program)

DENTAL SERVICE PLANS

There are two ILWU-PMA Welfare Plan Dental Programs: They are:

Children's Program to age 19 — Group Number 1
Adult Program — Group Number 1713

Benefits under the two programs are provided by Delta Dental Plan of California, Oregon Dental Service and Washington Dental Service dependent upon the patient's place of residence. (Delta Dental Plan of California processes claims for Eligible Persons living outside the states of California, Oregon and Washington). When the words SERVICE PLAN are used in the brochure, if refers to a State Dental Service Plan.

HOW TO USE YOUR DENTAL PROGRAM

Visit any licensed dentist. (See information below on participating dentists). Most dentists in California, Oregon and Washington are familiar with Delta Dental Plan and have the necessary claim forms. If not, claim forms may be obtained by contacting the appropriate State Dental Service Plan listed on page 1.

For Adult Program services, tell your dentist to use Group No. 1713 to identify your dental program. For Children's Program services, use Group No. 1. In all cases the social security number of the employee or surviving spouse must be used. No identification card is necessary.

PARTICIPATING DENTISTS

A participating dentist is a licensed dentist who is a member of Delta Dental Plan. (Information about participating dentists in your area is available from your State Dental Service Plan.) Selecting a participating dentist assures direct payment to the dentist and a guarantee of the maximum benefits payable under the Adult's and Children's program.

DEFINITIONS — UCR

Each of the words in the term "Usual, Customary and Reasonable" as used herein shall have the following meanings:

USUAL — A usual fee is the fee regularly charged and received

for a given service by an individual Dentist, i.e. his own usual fee. If more than one fee is charged for a given service, the fee determined to be the usual fee shall not exceed the lowest fee which is regularly charged or which is offered to patients.

CUSTOMARY — A fee is customary when it is within the range of usual fees charged and received by dentists of similar training for the same service within the geographic area determined by Delta to the statistically relevant.

REASONABLE — A fee is reasonable if it is "usual" and "customary" or if it falls above "customary" and is justifiable due to the level of treatment superior to that customarily provided. Additionally, a specific fee to a specific patient is reasonable if it is justifiable considering special circumstances, or extraordinary difficulty, of the case in question.

BENEFITS PROVIDED BY THE PROGRAM

Your Program covers the following services when they are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice. (Please refer to Group 1 Benefits on page 18 for a description of additional services covered only under the Children's Program.) Your Program covers only the cost of the Dentist's services. See also **Limitations and Exclusions**.

I. DIAGNOSTIC AND PREVENTIVE BENEFITS

Diagnostic — oral examination, x-rays, study models, biopsy/tissue examination, emergency treatment, consultation by a specialist.

Preventive — prophylaxis (cleaning), fluoride treatment, space maintainers.

II. BASIC BENEFITS

Oral surgery — extractions and certain other surgical procedures, including pre- and post-operative care.

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

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

Endodontic — treatment of the tooth pulp.

Periodontic — treatment of gums and bones that support the teeth.

III. CROWNS, JACKETS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS

Crowns, jackets, inlays, onlays and cast restorations are benefits only if they are provided to treat cavities that cannot be directly restored with amalgam, synthetic, plastic or resin fillings.

IV. PROSTHODONTIC BENEFITS

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

THE IMPORTANCE OF PREDETERMINATION OF BENEFITS

After an examination, your dentist will talk to you about treatment you may need. THE COST OF TREATMENT IS SOMETHING YOU MAY WANT TO CONSIDER. IF THE SERVICE IS EXTENSIVE AND INVOLVES CROWNS OR BRIDGES, OR IF THE SERVICE WILL COST MORE THAN $100, WE ENCOURAGE YOU TO ASK YOUR DENTIST TO REQUEST A PREDETERMINATION.

A predetermination does not guarantee payment. It is an estimate of the amount the Service Plan will pay if you are eligible and meet all the requirements of your program at the time the treatment you have planned is completed.

In order to receive predetermination, your dentist must send an Attending Dentist's Statement to us listing the proposed treatment. The Service Plan will send your dentist a Notice of Predetermination which estimates how much of the treatment costs we will pay and how much you will have to pay. After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the statement to us for payment when treatment has been completed.

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued if the patient is eligible. Payment will depend on the patient's eligibility when completed services are submitted to the Service Plan.

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

SAVING MONEY ON YOUR DENTAL BILLS

You can keep your dental expenses down by:

1. Comparing the fees of different dentists;

2. Using a Delta Dentist;

3. Having your dentist obtain predetermination from the Service Plan for any treatment over $100;

4. Visiting your dentist regularly for checkups;

5. Following your dentist's advice about regular brushing and flossing;

6. Not putting off treatment until you have a major problem; and

7. Learning the facts about overbilling. Under this program, you must pay the dentist your copayment share. You may hear of some dentists who offer to accept insurance payments as "full payment." You should know that these dentists may do so by overcharging your program and may do more work than you need, thereby increasing program costs. You can help keep your dental benefits intact by avoiding such schemes.

PAYMENT

The Service Plan will pay Dentists directly. Our agreement with our Delta Dentists makes sure that you will not be responsible to the dentist for any money the Service Plan may owe. However, if for any reason the Service Plan fails to pay a dentist who is not a Delta Dentist, you may be liable for that portion of the cost. If you have selected a non-participating dentist, the Service Plan will pay you. Payments made to you are not assignable (in other words, Service Plan will not grant requests to pay non-participating dentists directly).

The Service Plan does not pay Delta Dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

Payment for any Single Procedure which is a covered service will only be made upon completion of that procedure. The Service Plan does not make or prorate payments for treatment in progress or incomplete procedures. The date the procedure is completed governs the calculation of any deductible under your program.

If there is a difference between what your dentist is charging you and what the Service Plan says your portion should be, or if you are not satisfied with the dental work you have received, contact Service Plan's Customer and Member Service Department. The Service Plan may be able to help you resolve the situation.

The Service Plan may deny payment of an Attending Dentist's Statement for services submitted more than six months after the date the services were provided. If a claim is denied due to a Delta Dentist's failure to make a timely submission, you shall not be liable to that dentist for the amount which would have been payable by the Service Plan (unless you failed to advise the dentist of your eligibility at the time of treatment).

The processes the Service Plan uses to determine or deny payment for services are distributed to all Delta Dentists. They describe in detail the dental procedures covered as Benefits, the conditions under which coverage is provided, and the limitations and exclusions applicable to the program. Claims are reviewed for eligibility and are paid according to these processing policies. Those claims which require additional review are evaluated by Service Plan's dentist consultants. If any claims are not covered, or if limitations or exclusions apply to services you have received from a Delta Dentist, you will be notified by an adjustment notice on the Notice of Payment or Action. You may contact Service Plan's Customer and Member Service Department for more information regarding processing policies.

SECOND OPINIONS

The Service Plan obtains second opinions through Regional Consultant members of its Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided.

The Service Plan will authorize such an examination prior to treatment when necessary to make a Benefits determination in response to a request for a Predetermination of treatment cost by a dentist. The Service Plan will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided. The Service Plan will notify the Enrollee and the treating dentist when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta to perform the clinical examination. When Service Plan authorizes a second opinion

through a Regional Consultant, it will pay for all charges.

Enrollees may otherwise obtain second opinions about treatment from any dentist they choose, and claims for the examination or consultation may be submitted to the Service Plan for payment. The Service Plan will pay such claims in accordance with the Benefits of the program.

This is only a summary of Service Plan's policy on second opinions. A copy of Service Plan's formal policy is available from Service Plan's Customer and Member Service Department upon request.

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.

COMPLAINT PROCEDURE, CLAIMS APPEAL AND ARBITRATION

If you have any questions about the services you receive from a Delta Dentist, Service Plan recommends that you first discuss the matter with your dentist. If you continue to have concerns, contact Service Plan at one of the numbers shown on page 1.

The Service Plan will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for denial. If you have a question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures and operations of Service Plan, or the quality of dental services performed by a Delta Dentist, you may contact Service Plan at the telephone number shown on page 1. You have 60 days after you receive notice of denial to appeal. If you write, you must include the name of the patient, the group name and number, the Eligible Employee's name and social security number or identification number and your telephone number on all correspondence. You should also include a copy of the treatment form, Notice of Payment and any other

relevant information. Clearly explain your complaint and send it to Service Plan at the address shown on page 1.

The Service Plan will review your complaint and will respond to it within 30 days unless more information or time is needed to resolve the matter. Service Plan may need more time if your complaint is referred to a dental consultant or to a peer review committee of the local dental society. If a referral is necessary, a reply will be sent to you in no more than 120 days after Service Plan receives your complaint. The Service Plan will respond within five days of receipt to complaints involving imminent and serious threat to a patient's health.

You may file a complaint with the Department of Corporations after you have completed Delta's grievance process or after you have been involved in Service Plan's grievance process for 60 days. You may file a complaint with the Department immediately in an emergency situation which is one involving imminent and serious threat to your health.

The California Department of Corporations is responsible for regulating health care service plans. The Department has a toll-free number **1 (800) 400-0815** to receive complaints regarding health plans. If you have a grievance against the health plan, you should contact the plan and use the plan's grievance process. If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, you may call the Department's toll-free telephone number.

Disputes relating to your plan, including claim denials, may be settled by arbitration if they cannot be settled by this complaint process. Arbitration will follow the Commercial Rules of the American Arbitration Association. You can begin this process by giving written notice to each party (for example, Service Plan and your dentist) with whom you want to arbitrate, explaining the dispute and the amount involved, if any, and the solution you wish. You must then file two copies of the notice with the Association's regional office in Los Angeles, or San Francisco, along with the fee required by the Association.

In the event of extreme hardship on the part of an Enrollee or subscriber, and upon an application for relief presented to the AAA, Service Plan shall assume all or a portion of the arbitration fees and expenses as determined by the AAA in accordance with procedures established and administered by the AAA.

IF YOU HAVE ADDITIONAL COVERAGE

It is to your advantage to let your dentist and Service Plan know if you have dental coverage in addition to this program. Most dental carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs — sometimes paying 100% of your dental bill. For example, you might have some fillings that cost $100. If the primary carrier usually pays 80% for these services, it would pay $80. The secondary carrier might usually pay 50% for this service. In this case, since payment is not to exceed the entire fee charged, the secondary carrier pays the remaining $20 only. Since this method pays 100% of the bill, you have no out-of-pocket expense.

Be sure to advise your dentist of all programs under which you have dental coverage and have him or her complete the dual coverage portion of the Attending Dentist's Statement, so that you will receive all benefits to which you are entitled. For further information, contact the Service Plan Customer and Member Service Department at the number shown on page 1.

EXTENSION OF BENEFITS

All benefits cease on the date coverage terminates (see page 11 and 18); however, coverage will be extended to Basic and Prosthodontic Services that have been submitted on an Attending Dentist's Statement for predetermination and approved prior to the date of termination if these services are completed within 60 days of the date of approval by the Service Plan and while the Group Dental Agreement is still in effect.

CANCELLATION AND RENEWAL

This Dental Care Program may be cancelled by the Service Plan only on an anniversary date (two years after the Program first takes effect or at the end of each one year period thereafter). Upon cancellation of the Program, individual members of the group and their dependents have no right to renewal or reinstatement.

FUNDING POLICY AND PAYMENT OF DUES

The funding policy and method require the payment of monthly dues for group #1713 and monthly reimbursement of the amount of paid dental expenses for group #1 to the State Dental Service Plans as specified to the Group Dental Agreement. No employee contributions are required.

DUAL CHOICE

Eligibles who live in the San Francisco Bay Area, the Los Angeles Harbor Area or the Portland-Vancouver Area have a choice of dental coverage between the Service Plan and a dental group practice plan. A choice may be made when originally eligible or each year in the month of May. Information about the choice is made available by the ILWU-PMA Welfare Plan Office.

ADULT PROGRAM GROUP NUMBER 1713

PARTICIPANT ELIGIBILITY & EFFECTIVE DATE OF COVERAGE

The benefits described in this brochure are provided to eligibles according to the Third Amended ILWU-PMA Welfare Agreement.

Eligibles include active and retired employees, and qualified surviving spouses of active and retired employees. Qualified dependents are also covered and include the eligible employee's or pensioner's spouse, unmarried dependent children between ages 19 and 23 who are full-time students, and incapacitated dependent children ages 19 and over.

TERMINATION OF COVERAGE

Eligibility under Group No. 1713 ends upon:

— Loss of eligibility under the ILWU-PMA Welfare Plan.

— Election under Optional Continuation of Coverage (COBRA).

— Election of an alternate dental plan.

For any Benefits that might be payable after termination see "Extension of Benefits" on page 10.

OPTIONAL CONTINUATION OF COVERAGE (COBRA)

You may be entitled to continue your coverage under this program, at your expense, following the occurrence of certain "Qualifying Events," if certain conditions are met. The length of time during which you may continue your coverage depends upon the "Qualifying Event(s)" which trigger this option.

The "Qualifying Events" are:

1. The Primary Enrollee's termination of employment, other than

for gross misconduct, or his/her reduction in work hours to less than the minimum required to be eligible under this program;

2. The Primary Enrollee's death;

3. A divorce or legal separation from the Primary Enrollee;

4. An enrolled dependent child's loss of eligibility as a dependent.

Primary Enrollees and their Dependent Enrollees may continue coverage for 18 months following the occurrence of Qualifying Event 1. However, if the Enrollee was disabled at any time during the first 60 days of this continued coverage, the Enrollee's and Dependent Enrollee's coverage may be continued for a total of 29 months, provided:

There is a determination under Title II or Title XVI of the Social Security Act that the disabled person was disabled at the time Qualifying Event 1 occurred; and

Notice of the Title II or Title XVI determination is given to Service Plan during the initial 18 months of continued coverage and within 60 days of the date of the determination.

Extended coverage under these conditions ends on the first of the month that begins more than 30 days after the date of the final determination that the Enrollee is no longer disabled. The Enrollee must notify the employer within 30 days of any such determination.

Enrollees who have continued coverage for 18 months because of Qualifying Event 1 (above), and who then experience a second Qualifying Event (2, 3 or 4) during the first 18 months of continued coverage may choose to continue coverage for up to a total of 36 months after the first Qualifying Event.

Enrollees who experience Qualifying Event 2, 3 or 4 as their first Qualifying Event may choose to continue coverage for 36 months following that Qualifying Event.

When an employer has filed for bankruptcy under Title II, United States Code, benefits may be substantially reduced or eliminated for retired Primary Enrollees their Dependent Enrollees, or the surviving spouse of a deceased retired Primary Enrollee. If this benefit reduction or elimination occurs within one year before or one year after the filing under Title II, it is considered a Qualifying Event. A retired Primary Enrollee who has lost coverage because of this Qualifying Event may choose to continue coverage until his or her death. Dependent Enrollees losing coverage because of this Qualifying Event may choose to continue coverage for up to 36 months after the death of the retired Primary Enrollee.

How You Continue Coverage Under This Option

If you or your enrolled dependent(s) wish to continue coverage, you must notify the ILWU-PMA Welfare Plan Office within 60 days after a divorce or legal separation or if an enrolled dependent child loses eligibility. Otherwise, the option of continued coverage based on one of these events will be lost.

Once the Welfare Plan Office has been made aware of a Qualifying Event, the Plan will notify affected persons about their right to continue their coverage. This notice will include the amount of monthly dues the employer will charge them for continued coverage as allowed by law. If you or any of your enrolled dependents wish to continue coverage, the Welfare Plan Office must be notified within 60 days after you or they receive notice or 60 days after losing coverage because of the Qualifying Event, whichever is later. You or your dependent will then have 45 days to pay the Plan the initial installment of dues, which must include the dues for each month since the Qualifying Event.

Continued coverage will be the same as you would receive if you were still an Enrollee. If the Welfare Plan changes the coverage for regular employees, your continued coverage will change as well.

Your continued coverage will end at the end of the month in which any of the following events first occur:

1. The allowable number of consecutive months of continued coverage is reached;

2. The dental program ends;

3. Dues are not paid as required;

If after you have elected this Continuation of Coverage option, you (or your dependents) become covered or entitled to either items 4 or 5 below, your Continuation of Coverage option may be terminated.

4. Dental benefits under another group health plan (as an employee or a dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such a person, if that pre-existing condition is covered under this program; or

5. Medicare.

For purposes of this continued coverage, Dependent Enrollee will include any child born to or adopted by the Primary Enrollee during continued coverage.

Once continued coverage ends, it cannot be reinstated.

COVERED SERVICES

Covered Services are listed on page 4 of this brochure.

AMOUNT PAYABLE

For BASIC AND PROSTHODONTIC SERVICES the Service Plan will pay 80% of the participating dentist's Usual, Customary and Reasonable fees.

Payment to non-Delta Dentist for Basic and Prosthodontic Services shall be calculated based on the lesser of the fee charged or the fee which satisfies the majority of the Service Plan's participating dentists.

LIMITATIONS AND EXCLUSIONS

LIMITATIONS ON DIAGNOSTIC AND PREVENTIVE BENEFITS

a) An oral examination is a benefit only if the Dentist has an accepted fee on file with the Service Plan for this procedure and shall not be provided more than twice in a calendar year while the patient is an Eligible Person under any Service Plan program.

b) Prophylaxes (cleanings), fluoride treatments or procedures that include cleanings are benefits twice in a calendar year while the patient is an Eligible Person.

c) Unless special need is shown, full-mouth x-rays are benefits once in a five-year period under any Service Plan program. Supplementary bitewing x-rays are benefits twice in a calendar year for children to age 18 or once in a calendar year for adults age 18 and over under any Service Plan program.

LIMITATION ON BASIC BENEFITS

Periodontal procedures that include cleanings are limited under General Limitations.

LIMITATION ON CROWNS, JACKETS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS

Crowns, jackets, inlays, onlays and cast restorations are benefits on the same tooth only once every five years while you are eligible under any Service Plan program.

LIMITATIONS ON PROSTHODONTIC BENEFITS

a) Prosthodontic appliances (including, but not limited to, fixed bridges and partial or complete dentures) are benefits only once every five years while you are eligible under any Service Plan program, unless Service Plan determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement will be made of a prosthodontic appliance not provided under a Service Plan program only if it is unsatisfactory and cannot be made satisfactory.

b) The Service Plan will pay up to the maximum applicable allowance (see Amount of Benefits Payable) of the dentist's fee for a standard cast chrome or acrylic partial denture or a standard complete denture, up to a maximum fee allowance. This fee allowance is the fee that would satisfy the majority of Service Plan Dentists for a *standard* denture. (A "*standard*" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials). The maximum fee allowance is revised periodically, as dental fees change. If your dentist's accepted fee on file with the Service Plan for a partial or complete denture is higher than this maximum allowance, you

must pay that portion of his or her fee that exceeds the Service Plan allowance in addition to your portion of the allowance.

c) Implants (appliances inserted into bone or soft tissue) or the removal of implants are not covered by your program. However, if implants are provided along with a covered prosthodontic appliance, the Service Plan will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If the Service Plan makes such an allowance, the Service Plan will not pay for any replacement for five years following the completion of the service.

GENERAL LIMITATION — Optional Services

If an Enrollee selects a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, the Service Plan will pay the applicable percentage (see Amount of Benefits Payable) of the lesser fee for the customary or standard treatment and the patient is responsible for the remainder of the dentist's fee.

For example: a crown where a silver filling would restore the tooth; a gold crown where one constructed of semi-precious materials would restore the tooth; or a precision denture where a standard denture would suffice.

EXCLUSIONS/SERVICES WE DO NOT COVER

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws or services which are paid by any federal, state or local government agency, except Medi-Cal benefits.

2. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

3. Treatment which restores tooth structure that is worn; treatment which rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion; or treatment which stabilizes the teeth. Examples of such treatment are equilibration and periodontal splinting.

4. Any Single Procedure, bridge, denture or other prosthodontic service which was started before you were covered by this program.

5. Prescribed drugs, premedication or analgesia.

6. Experimental procedures.

7. Prophylaxis, if the Eligible Patient has received two prophylaxes covered by the Program in a calendar year.

8. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

9. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.

10. Grafting tissues from outside the mouth to tissue inside the mouth ("extraoral grafts"), implants (materials implanted into bone or soft tissue) or the removal of implants.

11. Services for any disturbances of the jaw joints (temporomandibular joints or "TMJ") or associated muscles, nerves or tissues.

12. Orthodontic services.

13. Care otherwise provided under the ILWU-PMA Welfare Plan.

CHILDREN'S PROGRAM GROUP NUMBER 1

PARTICIPANT ELIGIBILITY & EFFECTIVE DATE OF COVERAGE

The benefits described in this brochure are provided to eligibles according to the Third Amended ILWU-PMA Welfare Agreement. Eligibles include children to age 19 of active and retired employees and qualified surviving spouses with Welfare Plan eligibility. To be eligible, children (including step-children, adopted children, children placed for adoption, and foster children) must be unmarried and dependent upon the employee or surviving spouse for support and maintenance. Children in military service are not eligible.

TERMINATION OF COVERAGE

Eligibility for children covered under Group No. 1 ends upon:

— The child's 19th birthday.

— The child's date of marriage if prior to 19th birthday.

— When the employee or surviving spouse through whom the child has coverage loses Welfare Plan Eligibility.

— Cancellation of Enrollment.

— Election under Optional Continuation of Coverage (COBRA).

Except for Orthodontic Services, dental care authorized prior to loss of eligibility will be covered by the Dental program if it is completed within the period of authorization.

For any benefits that might be payable after termination, see "Extension of Benefits" on page 10.

See also "Optional Continuation of Coverage" on page 11 for information about self-paid continued coverage under the federal law known as "COBRA".

BENEFITS PROVIDED BY THE PROGRAM

Benefits provided by the program are listed on page 4 of this brochure. In addition the following benefits are provided under Children's Program Group Number 1 only.

■ In the event it is the opinion of the dentist and the Service Plan that care other than that provided by the dentist, such as hospitalization, is essential to an individual child's dental health, and such care is not otherwise covered under the ILWU-PMA Welfare Plan, such care may be authorized by the Service Plan under this Program.

■ ORTHODONTIC SERVICES are a provision of Group Number 1. Orthodontic Services are defined as procedures by a licensed dentist, involving the use of an Orthodontic appliance, for treatment of malalignment of teeth and/or jaws which significantly interferes with their function. Orthodontic treatment is available only to eligible dependent children.

■ SEALANTS — topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay are a provision of Group No. 1 only, and are limited to Eligible Dependent children under age 14.

AMOUNT PAYABLE

For BASIC AND PROSTHODONTIC SERVICES the Service Plan will pay 100% of the participating dentist's Usual, Customary and Reasonable fees.

Payment to non-participating dentists for Basic and Prosthodontic Services shall be calculated based on the lesser of the fee charged or the fee which satisfies the majority of the Service Plan's participating dentists.

For Orthodontic Services the Service Plan will pay 90% of the dentist's Usual, Customary and Reasonable fees.

PAYMENT

Participating dentists have agreed to accept the Service Plan's payment as FULL PAYMENT for all services covered by the Children's Program. Payment is made by the Service Plan directly to your dentist. You do not pay for any services provided by a participating dentist, (except for orthodontia as described above) unless a child has care excluded under the Children's program.

LIMITATIONS AND EXCLUSIONS

LIMITATIONS ON DIAGNOSTIC AND PREVENTIVE BENEFITS

a) An oral examination is a benefit only if the Dentist has an accepted fee on file with the Service Plan for this procedure and shall not be provided more than twice in a calendar year while the patient is an Eligible Person under any Service Plan program.

b) Prophylaxes (cleanings), fluoride treatments or procedures that include cleanings are benefits twice

in a calendar year while the patient is an Eligible Person.

c) Unless special need is shown, full-mouth x-rays are benefits once in a five-year period under any Service Plan program. Supplementary bitewing x-rays are benefits twice in a calendar year for children to age 18 or once in a calendar year for adults age 18 and over under any Service Plan program.

LIMITATIONS ON BASIC BENEFITS

a) Periodontal procedures that include cleanings are subject to the same limitations as other cleanings: i.e., cleanings of any kind are benefits no more than twice in a calendar year.

b) Sealant benefits are available to eligible persons under the age of 14. Sealant benefits include the application of sealants only to permanent posterior molar teeth without caries (decay), without restorations and with the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

LIMITATION ON CROWNS, JACKETS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS

Crowns, jackets, inlays, onlays and cast restorations are benefits on the same tooth only once every five years while you are eligible under any Service Plan program.

LIMITATIONS ON PROSTHODONTIC BENEFITS

a) Prosthodontic appliances (including, but not limited to, fixed bridges and partial or complete dentures) are benefits only once every five years while you are eligible under any Service Plan program, unless Service Plan determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement

will be made of a prosthodontic appliance not provided under a Service Plan program only if it is unsatisfactory and cannot be made satisfactory.

b) The Service Plan will pay 100% of the dentist's fee for a *standard* cast chrome or acrylic partial denture or a standard complete denture, up to a maximum fee allowance. This fee allowance is the fee that would satisfy the majority of Service Plan Dentists for a standard denture. (A "*standard*" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials). The maximum fee allowance is revised periodically, as dental fees change. If your dentist's accepted fee on file with the Service Plan for a partial or complete denture is higher than this maximum allowance, you must pay that portion of his or her fee that exceeds the Service Plan allowance in addition to your portion of the allowance.

c) Implants (appliances inserted into bone or soft tissue) or the removal of implants are not covered by your program. However, if implants are provided along with a covered prosthodontic appliance, the Service Plan will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If the Service Plan makes such an allowance, the Service Plan will not pay for any replacement for five years following the completion of the service.

GENERAL LIMITATION — Optional Services

If an Enrollee selects a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, the Service Plan will pay the applicable percentage (see Amount of Benefits Payable) of the lesser fee for the

customary or standard treatment and the patient is responsible for the remainder of the dentist's fee.

For example: a crown where a silver filling would restore the tooth; a gold crown where one constructed of semi-precious materials would restore the tooth; or a precision denture where a standard denture would suffice.

LIMITATIONS ON ORTHODONTIC BENEFITS

a) If orthodontic treatment is begun before you become eligible for coverage, Service Plan's payments will begin with the first payment due to the dentist following your eligibility date. The maximum amount payable by the Service Plan for orthodontics (see amount of Benefits Payable) will apply fully to this and subsequent payments.

b) The Service Plan's payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed or the date the Dependent Child loses eligibility or the termination date of the Contract, whichever shall occur first.

c) X-rays and extractions that might be necessary for orthodontic treatment are not covered by orthodontic benefits, but may be covered under Diagnostic and Preventive or Basic Benefits.

EXCLUSIONS/SERVICES WE DO NOT COVER

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws or services which are paid by any federal, state or local government agency, except Medi-Cal benefits.

2. Services for cosmetic purposes only.

3. Treatment which restores tooth structure that is worn; treatment which rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion; or treatment which stabilizes the teeth. Examples of such treatment are equilibration and periodontal splinting.

4. Any Single Procedure, bridge, denture or other prosthodontic service which was started before you were covered by this program.

5. Prescribed drugs, premedication or analgesia.

6. Experimental procedures.

7. Prophylaxis, if the Eligible Patient has received two prophylaxes covered by the program in a calendar year.

8. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

9. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.

10. Grafting tissues from outside the mouth to tissue inside the mouth ("extraoral grafts"), implants (materials implanted into bone or soft tissue) or the removal of implants.

11. Services for any disturbances of the jaw joints (temporomandibular joints or "TMJ") or associated muscles, nerves or tissues.

12. Orthodontic Services (treatment of malalignment of teeth and/or jaws), except those services provided to Eligible Dependent Children as described in Benefits Provided by the Program which are subject to the Limitations on Orthodontic Benefits and Exclusions 13 and 14 below.

13. Charges for cost of replacement and/or repairs of an orthodontic appliance furnished in whole or in part under this program.

14. Surgical procedures for correction of malalignment of teeth and/or jaws.

15. Care otherwise provided under the ILWU-PMA Welfare Plan.

IMPORTANT

This evidence of coverage constitutes only a summary of the group dental agreements between the Trustees of the ILWU-PMA Welfare Plan and the State Dental Service Plans. It does not describe every provision of the program, or of the ILWU-PMA Welfare Agreement. The group dental agreements must be consulted to determine the exact terms and conditions of coverage. This evidence of coverage is subject to the provisions of the group dental agreement, and cannot modify or affect the group dental agreement in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE DENTAL PLAN. THE DENTAL PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

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

A SUPPLEMENTAL SUMMARY PLAN DESCRIPTION INSERT
DELTA DENTAL PLAN

JANUARY 2001

(Revisions to the February, 1999 Delta Dental Plan Supplemental Summary Plan Description.)

Names of Trustees:

Union Trustees	Robert M. McEllrath Ray Ortiz, Jr. Joseph Wenzl	**Employer Trustees**	James R. Britton R.P. Holbrook Paul Lundberg

Page 11, **Dual Choice** - Eligibles who live in the San Francisco Bay Area, the Los Angeles Harbor Area or the Portland/Vancouver Area have a choice of dental coverage between the Service Plan and a dental group practice plan. The choice is offered when eligibility is first obtained, and each year in May for coverage effective July 1. In addition to the May open enrollment period, participants may change their dental plan coverage once at any time during the Plan Year (July 1 – June 30). Information about the choice is made available by the Welfare Plan office.

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