# STA-ILA Benefits Trust Fund

**Steamship Trade Association of Baltimore, Incorporated**

**International Longshoremen's Association**

# STA-ILA Benefits Plan For Pensioners

# Summary Plan Description

**Amended and Restated**
**October 1, 2021**

**STA-ILA BENEFITS TRUST FUND**
**Holabird Business Park**
**6610 Tributary Street**
**Baltimore, Maryland 21224-6514**
**(410) 633-9311**
**www.stailafunds.com**

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# STA-ILA Benefits Trust Fund

Holabird Business Park
6610 Tributary Street
Baltimore, Maryland 21224-6514
www.stailafunds.com

October 2021

To All Covered Pensioners:

The STA-ILA Benefits Trust Fund ("Fund") sponsors the STA-ILA Benefits Plan for Pensioners ("Plan"), which provides supplemental benefits to you and your Spouse. This supplemental program consists of the following benefits:

- Dental Benefits;
- Vision Care Benefits;
- Hearing Aid Reimbursement Benefits;
- Specialist Reimbursement Account;
- Life Insurance Benefits;
- Dependent Spouse Death Benefit; and
- Burial Benefits.

The Management-International Longshoremen's Association Managed Health Care Trust Fund ("MILA") provides certain dental and vision benefits to Participants and their Dependents as defined by the MILA eligibility rules. These "supplemental" dental and vision benefits are administered by MILA, and funded by the STA-ILA Benefits Trust Fund to the extent that they are in excess of the standard dental and vision benefits generally provided by MILA. Any questions, concerns, claims,, or appeals regarding dental or vision benefits should be addressed to the MILA Plan Administrator.

This Summary Plan Description ("SPD") provides you with an up-to-date description of the benefits available to you and your Spouse or Pensioned Spouse from the Plan. This SPD does not contain the provisions of the Agreement and Declaration of Trust under which the Fund operates. The Fund is administered by the Board of Trustees in accordance with this SPD.

*Your SPD includes a new section called "Life Events." Beginning on page 7, this section explains how your benefits may be affected by certain events (marriage, divorce, etc.). The language in this brief section has been written to be easily to read and understood, and avoids any "legalese." We encourage you to refer to this section as a first-step in the event you experience a life-changing event.*

We encourage you to contact the Fund Office with any questions you may have concerning your Plan or its administration. The Fund Office personnel will help you identify the rules of the Plan and will refer you to pertinent provisions in this SPD. Only the full Board of Trustees, however, is authorized to interpret the Plan rules, as set forth herein. No Employer, Union, or representative of any Employer or Union acting in such capacity is authorized to interpret this Plan, nor can any person, including Fund Office personnel, act as an agent for the Trustees with respect to questions of interpretation.

Although this Plan is intended to be maintained indefinitely, the Board of Trustees specifically reserve the right to change the Plan's provisions, terminate the Plan, and add to or delete from the Benefit Schedule provided to Pensioners and their Spouses. The Board also reserves the right to adopt new Plan rules and regulations or to modify the existing rules and regulations. Nothing in this SPD or elsewhere should be construed to mean that the Plan's benefits are guaranteed. The Plan will, of course, notify you when significant changes are made effecting the rules, regulations, or Benefit Schedule.

Since the purpose of the Plan is to benefit you and your Spouse exclusively, please read this SPD carefully so that you understand the benefits as well as the eligibility rules and procedures for filing claims. We suggest you keep this SPD and any modifications with your important papers and share it with your Dependents. We also encourage you to visit the Plan's website at www.stailafunds.com where you can find information about your benefits and eligibility, forms, and important contact numbers.

Sincerely,

Board of Trustees

Disclaimer: Please note that the information presented is for informational purposes only and does not constitute legal, tax, or investment advice. You should discuss any issues you may have with your legal, tax, and other advisors before making determinations and decisions about your specific situation.

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# Your STA-ILA Benefits Plan

Your STA-ILA Benefits Plan ("Plan") is a supplemental benefits program designed to pay certain covered expenses of yourself, your Spouse or a Pensioned Spouse in time of Illness and Injury. It is also designed to encourage you and your Spouse to stay in good health.

Your Plan provides benefits to you for your supplemental Medically Necessary covered expenses after your retirement under the STA-ILA Pension Plan. Benefits provided for active Employees differ from benefits provided for Pensioners, and are described in the STA-ILA Benefits Plan for Active Employees Summary Plan Description ("SPD").

| CONTACT INFORMATION | |
|---|---|
| **Fund Office** | STA-ILA Benefits Trust Fund<br>Holabird Business Park<br>6610 Tributary Street<br>Baltimore, MD 21224-6514<br>(410) 633-9311<br>(410) 633-9347 Fax |
| **Specialist Reimbursement Account** | Fund Office |
| **Hearing Aid Reimbursement** | Fund Office |
| **Life Insurance Benefit** | The Hartford Life and Accident Insurance Company<br>One Hartford Plaza<br>Hartford, CT 06155<br>www.thehartford.com |
| **International Longshoremen's Association** | 6610 Tributary Street<br>Baltimore, MD 21224-6514<br>(410) 631-7271 |
| **Steamship Trade Association of Baltimore, Inc.** | 8615 Ridgelys Choice Drive<br>Suite 202<br>Baltimore, MD 21236-3028<br>(410) 248-3377 |

# Definitions

There are certain words and phrases used frequently throughout this Summary Plan Description ("SPD") that you should know. They will help you understand your benefits better.

## Association

The Steamship Trade Association of Baltimore, Incorporated (STA).

## Benefits Fund Participation Agreement

An agreement between an Employer and the Union in form and content acceptable to the Board of Trustees that evidences the obligation of the signatory thereto to be bound by the Trust Agreement and the actions of the Board of Trustees.

## Calendar Year

The twelve-month period beginning on January 1 and ending on December 31, is used for the purpose of benefit coverage.

## Collective Bargaining Agreement

The agreement between an Employer and the Union requiring contributions to the Fund, together with any written modifications, supplements, or amendments thereto which have been accepted by the Trustees as the basis for an Employer's participation in the Fund, as changed from time to time.

## Employee

You are considered an Employee if:

- you work for one or more Employers and the work you perform is covered by the Collective Bargaining Agreement between the Association and the Union in the Port of Baltimore and vicinity;

- you work for one or more Employers, were formerly covered by the Collective Bargaining Agreement, still are working in the longshore industry, and are included in the Plan under a Benefits Fund Participation Agreement between your Employer and the Fund;

- you are an Employee of the Union, and the Union has executed the necessary Benefits Fund Participation Agreement authorizing your participation, and the Trustees have accepted this Agreement; or

- you are a member of the Fund Office staff of the STA-ILA Pension Fund, STA-ILA Benefits Trust Fund, STA-ILA Severance and Annuity Fund, STA of Baltimore- ILA Container Royalty Fund; or STA-ILA Vacation & Holiday Fund and there is a Benefits Fund Participation Agreement authorizing your participation in the Fund.

## Employer

The following organizations are considered Employers:

- members of the Association who are contributing to the Fund. (Contact the Fund Office to find out whether or not a member of the Association is considered an Employer for purposes of the Plan. If the Association member is considered an Employer, the Fund Office will give you the Employer's address);

- the Union;

- the STA-ILA Pension Fund, the STA-ILA Benefits Trust Fund and the STA-ILA Severance and Annuity Fund;

- the STA of Baltimore–ILA Container Royalty Fund and the STA-ILA Vacation & Holiday Fund; and

## General Exclusions

Any exclusions that apply to all benefits under the Plan, as shown later in this SPD.

## Illness

Any bodily sickness or disease, as diagnosed by a Physician and as compared to the person's previous condition.

## Incurred

The date on which a service or supply is furnished.

## Injury

An "injury" is a wound or damage to the body that is sustained accidentally and by external force.

## Medically Necessary

Services or supplies provided by a Physician or other medical provider that are used to treat an Injury or Illness according to standard medical practice, that are directly related to the care or treatment of the Pensioner, Spouse, or Pensioned Spouse, and that represent the most appropriate

level of care that can be provided safely. A service or supply is not automatically considered "medically necessary" just because it is prescribed by a Physician or other medical provider.

## Medicare

The insurance program established by Title XVIII of the Social Security Act of 1965, as originally enacted and subsequently amended.

## Participant

A Pensioner, Spouse, or Pensioned Spouse who has satisfied the Plan's eligibility requirements and who has actually enrolled in the Plan.

## Pensioned Spouse

A qualified widow or widower who is receiving pension benefits from the STA-ILA Pension Plan and who is the surviving Spouse of either a Pensioner retired under normal, early, service, or disability provisions or an active Employee who died with at least 20 Pension Credits.

## Pensioner

An Employee who is retired under the Normal, Early, Service, or Disability Retirement provisions of the STA-ILA Pension Plan.

## Physician or Provider

A doctor or oral surgeon licensed to practice medicine or perform surgery under the laws of the state where such services are performed, and who is acting within the scope of his license. A duly licensed practitioner who, under the supervision of a Physician, performs services that would be covered under this Plan if performed by the Physician is also treated as a "Physician."

## Plan

The STA-ILA Benefits Plan for Pensioners, as amended from time to time.

## Plan Year

The 12-month period beginning on October 1 and ending on September 30, used for purposes of eligibility.

## Provider

A physician or other health professional, who is licensed or certified under applicable state and federal law to provide covered health care services to you.

## Spouse

The Pensioner's legally married spouse, as determined by applicable state law and federal law.

## Union

The Baltimore District Council of the International Longshoremen's Association (ILA).

# Introduction

As a covered Pensioner, you become a Participant in the Plan and are entitled to benefits once you satisfy the eligibility requirements and enroll in the Plan. Generally, to be eligible to participate in this Plan, you must retire under the provisions of the STA-ILA Pension Plan.

The Board of Trustees shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of the Plan, and to determine all questions arising in connection with the administration, interpretation, and application of the Plan, including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any Plan document and any determination of fact adopted by the Board of Trustees shall be final and legally binding on all parties. Any interpretation, determination,, or other action of the Board of Trustees shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion.

# Life Events

As you experience certain "life events" (listed below), it is important to understand how your supplemental benefits through the STA-ILA Benefits Plan are affected.

Your supplemental benefits include:

- Dental Benefits
- Vision Care Benefits
- Hearing Aid Reimbursement Benefits
- Specialist Reimbursement Account Benefits
- Life Insurance Benefits
- Dependent Spouse Death Benefit
- Burial Benefits

You or a family member should contact the Fund Office by calling (410) 633-9311 if you experience any of the following:

- You get married
- You get divorced
- You add a dependent to your family
- You stop receiving pension benefits
- Your spouse dies
- You die
- Your pensioned spouse remarries

**Benefits Through MILA**

Remember, your medical, hospitalization, prescription drug, and primary dental, vision, and hearing aid coverages are provided through the Management-International Longshoremen's Association Managed Health Care Trust Fund ("MILA"). For information about how those benefits are affected when you experience a life event, please contact the MILA Plan Administrator.

## If You Marry

If you get married while a participant in the Plan, your spouse is eligible to enroll for coverage. You must file an Enrollment Card with the Fund Office within 60 days of the date of your marriage and provide your marriage certificate, birth certificates, and Social Security cards.

**The Plan defines spouse as a same or opposite-sex person to whom you are legally married.**

Although it is not required, you may wish to name your new spouse as your life insurance beneficiary. Contact the Fund Office for a "Change of Beneficiary" form if you would like to name your spouse as a beneficiary.

If your Spouse dies while you are covered by the Plan, you will be paid a Life Insurance Benefit. To receive this benefit, your Spouse's name must be on file at the Fund Office.

## If You Divorce

If you divorce, you must contact the Fund Office within 60 days of the effective date. Your former Spouse will no longer be eligible for Plan coverage if you divorce, but may be eligible to purchase COBRA Continuation Coverage for up to 36 months. He or she should contact the Plan Co-Administrator to enroll.

If you would like to change your beneficiary designation for your Life Insurance Benefit, contact the Fund Office. You may wish to change your designated beneficiary, if you had previously named your Spouse as your beneficiary for your Life Insurance Benefit.

## If Add a Dependent to Your Family

Although a new spouse is eligible for coverage under the Plan, dependent children and dependent parents are not eligible.

**Whenever you have a change in status, it is a good idea to review your beneficiary designation. Contact the Fund Office to make sure your beneficiary information is up-to-date.**

## If You Stop Receiving Pension Benefits

You must be receiving a pension from the STA-ILA Pension Fund to be eligible for Plan benefits for Pensioners. If your pension payments stop for any reason (such as engaging in unauthorized employment during your retirement), you will no longer be eligible for coverage under the Plan.

## If Your Spouse Dies

If your Spouse dies while you are covered by the Plan, contact the Fund Office within 60 days. You are eligible for a Dependent Spouse Death Benefit of $6,000. To receive this benefit, your Spouse's name must be on file at the Fund Office.

Make sure you alert the Co-Plan Administrator of your Spouse's death so that your records are updated. You may need to name a new beneficiary for your Life Insurance Benefit.

**What is a "Pensioned Spouse?"**
**A pensioned spouse is a qualified widow or widower who is receiving pension benefits from the STA-ILA Pension Plan and who is the surviving spouse of either a Pensioner retired under normal, early, service, or disability provisions or an active employee who died with at least 20 Pension Credits.**

*Burial/Cremation Benefit*

If your Spouse dies and was a "Pensioned Spouse"—receiving a pension benefit from the Pension Plan following your death—this Plan pays up to $5,000 toward burial or cremation expenses. To be eligible, a claim for payment must be made within one year of the date of your Pensioned Spouse's death.

## If You Die

If you die while covered by the Plan, your surviving spouse or other dependent should contact the Fund Office. Your beneficiary is eligible for a Life Insurance Benefit of $12,000. If your beneficiary dies before you or if you fail to name a beneficiary, the Life Insurance Benefit is paid to your estate. If your beneficiary is a minor, the Life Insurance Benefit is paid according to the rules established by the insurance company.

If you die and your spouse becomes a "Pensioned Spouse," he or she is eligible to continue coverage under this Plan. Refer to the Eligibility Section and the COBRA Continuation Coverage Section of this Summary Plan Description ("SPD") for details.

## If Your Pensioned Spouse Remarries

Coverage for your Pensioned Spouse will end under this Plan if he or she remarries. However, Pensioned Spouses who remarry are eligible for continuation coverage through COBRA for up to 36-months.

**If you move, keep in touch! Be sure to contact the Fund Office at (410) 633-9311 to make sure the address information on file is accurate.**

# Eligibility

When you become a Pensioner, the coverage you have as an active Employee continues until the end of the Calendar Year in which your pension is effective (unless the "Special Rules for Employees of the Fund Office Staff," discussed in the STA-ILA Benefits Plan for Active Employees SPD, apply to you). In some instances, this coverage may continue for an additional year. You will be notified by the Fund Office as to when your Pensioner coverage begins. The benefits provided to Pensioners are different from the benefits provided to active Employees.

## Eligibility for Pensioners

You are eligible for benefits under this Plan if you retire under the Normal, Early, Service, or Disability retirement provisions of the STA-ILA Pension Plan, or if you retire after your "Required Beginning Date" with at least 20 Years of Vesting Service (as defined in the STA-ILA Pension Plan). Pensioner coverage begins as soon as your active Employee coverage ends. If you retire on Early retirement between the ages of 50 and 54, you are eligible for Pensioner coverage at age 65.

Your Spouse, but not your Dependent Children or Dependent Parent (as defined in the Active Employees SPD), is eligible for the same coverage as you.

## Eligibility of Surviving Spouses of Certain Active Employees

The surviving Spouse of an active Employee is eligible for Pensioner coverage if the active Employee dies with at least 20 Pension Credits (as defined in the STA-ILA Pension Plan), or with at least 20 Years of Vesting Service if the Employee was active beyond his "Required Beginning Date." If the Employee died on or after attaining age 50, or if the Employee was eligible to retire on a Service Pension at the time of death (as provided for in the STA-ILA Pension Plan), the Pensioned Spouse is eligible for Pensioner coverage immediately after the active Employee coverage ends. However, if the Employee died prior to age 50 and was not eligible to retire on a Service Pension at the time of death, the Pensioned Spouse's coverage begins when the Employee would have been age 50, had he or she lived.

## Eligibility of Surviving Spouses of Pensioners

The surviving Spouse of a Pensioner ("Pensioned Spouse") is eligible for Pensioner coverage if he or she is eligible for pension benefits from the STA-ILA Pension Plan and the Pensioner had retired under a Normal, Early, Service, or Disability Pension.

## Termination of Eligibility

Coverage for you, your Spouse, or a Pensioned Spouse automatically terminates on the earliest of the following:

- The date the Plan is terminated;

- The date that coverage for Spouses or Pensioned Spouses under the Plan is terminated;
- The date you are no longer eligible to receive pension benefits from the STA-ILA Pension Plan;
- For you, the date of your death;
- For your Spouse, the date of death or divorce;
- For a Pensioned Spouse, the date of death or remarriage; or
- The date a claim is paid based on false information given intentionally or unintentionally. (Coverage resumes when the Plan is fully reimbursed for the improper payments).

# Enrollment

## In General

In addition to the eligibility requirements described in the Eligibility Section, above, an Enrollment Card for benefits coverage must be submitted to the Fund Office.

You must file an Enrollment Card in order to be eligible for Pensioner coverage. If you are married, you must name your Spouse and furnish a marriage and birth certificate, and all Social Security cards to the Fund Office.

The Enrollment Card, which you sign when you enroll for Pensioner coverage, is sufficient to provide coverage for your Spouse. If your Spouse becomes a Pensioned Spouse after your death, he or she must sign a new enrollment card.

If, after you have signed an Enrollment Card, your family status changes because of marriage, death, or divorce, etc., you must notify the Fund Office within sixty (60) days of the applicable event. Upon receipt of the appropriate documents, such as a marriage certificate, the Fund Office will adjust your records accordingly.

## HIPAA Special Enrollment Rights

This Plan complies with the special enrollment rights provided under the Health Insurance Portability and Accountability Act (HIPAA). If you are eligible for benefits and you acquire a new Spouse as a result of marriage, you may request enrollment for yourself and your Spouse within sixty (60) days after the marriage. Coverage will become effective as of the later of the date of marriage or the first day of the month following the month in which you provide the Fund Office with the required documentation.

In addition, if you declined coverage for yourself or your Spouse because of other health insurance or group health coverage, and you lose that coverage as a result of loss of eligibility or termination of employer contributions toward coverage, you may enroll yourself and your Spouse in this Plan provided that you request enrollment within sixty (60) days after your Spouse's other coverage ends (or after your Spouse's employer stops contributing toward the other coverage) and provided you meet all of the eligibility requirements described in this Summary Plan Description ("SPD"). Coverage will become effective no later than the first day of the month following a completed request for enrollment.

To request special enrollment in the Plan, contact the Fund Office at the phone number listed on the front of this SPD.

# COBRA Continuation Coverage

## When You May Be Entitled to COBRA Continuation Coverage

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), your Spouse or Pensioned Spouse may continue the same Dental Benefits, Vision Care Benefits, Hearing Aid Reimbursement Benefits, and Specialist Reimbursement Account Benefits temporarily at his or her own expense where the coverage otherwise would end due to a "Qualifying Event." COBRA does not cover Life Insurance Benefits or Burial Benefits.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

## What is a Qualifying Event?

Your Spouse or Pensioned Spouse may continue coverage, as described above, for 36 months if such coverage would otherwise end because of one of the following Qualifying Events:

- Your death (unless your Spouse is a Pensioned Spouse);
- Your divorce or legal separation; or
- If your Spouse is a Pensioned Spouse, he or she remarries. (Although remarriage is not considered a Qualifying Event under COBRA, the Plan provides a Pensioned Spouse with 36 months of COBRA coverage in the event that he or she loses Plan coverage because he or she remarries.)

## When is COBRA Continuation Coverage Available?

The Plan will offer COBRA Continuation Coverage to the Spouse or Pensioned Spouse only after the Plan Co-Administrator has been notified that a Qualifying Event has occurred. You, your Spouse, or your Pensioned Spouse should notify the Plan Co-Administrator promptly if one of the Qualifying Events listed in the paragraph above occurs in order to avoid confusion over the status of your Spouse or Pensioned Spouse's Plan coverage.

## You Must Give Notice of Some Qualifying Events

Your Spouse or Pensioned Spouse must notify the Plan Co-Administrator of your divorce or remarriage no later than sixty (60) days after the Qualifying Event occurs. The notice of occurrence of these events must be provided to the Plan Co-Administrator in writing by using the Plan's "COBRA Event Notice Form for Covered Employees and Qualified Beneficiaries"

(hereinafter, "Notice Form") to provide notice to the Plan Co-Administrator. This form may be obtained by contacting the Fund Office.

If you have any questions about how to provide a written notice of a Qualifying Event, please contact the Plan Co-Administrator. **Failure to provide notice within the form and timeframe described above may prevent your Spouse or Pensioned Spouse from obtaining COBRA coverage.**

## How is COBRA Continuation Coverage Provided?

Within thirty (30) days after the Plan Co-Administrator receives notice that a Qualifying Event has occurred, the Plan Co-Administrator will then provide your Spouse or Pensioned Spouse with notice of the date on which his or her coverage under the Plan will end, and the information and election form that he or she will need in order to elect COBRA Continuation Coverage. Under the law, your Spouse or Pensioned Spouse will then have only sixty (60) days from the later of the date he or she ordinarily would have lost coverage because of one of the Qualifying Events described above, or the date he or she received the notice, to apply for COBRA Continuation Coverage.

IF YOUR SPOUSE OR PENSIONED SPOUSE DOES NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN SIXTY (60) DAYS AFTER THE QUALIFYING EVENT (OR, IF LATER, WITHIN SIXTY (60) DAYS AFTER RECEIVING THAT NOTICE), HE OR SHE WILL LOSE THE RIGHT TO ELECT COBRA CONTINUATION COVERAGE.

In considering whether to elect COBRA Continuation Coverage, your Spouse or Pensioned Spouse should take into account [1]special enrollment rights under federal law. Your Spouse or Pensioned Spouse has the right to request special enrollment in another group health plan for which he or she is otherwise eligible within thirty (30) days after Plan coverage ends because of the qualifying event listed above. Your Spouse or Pensioned Spouse will also have the same special enrollment right at the end of COBRA Continuation Coverage if he or she gets continuation coverage for the maximum time available.

## Payment for COBRA Continuation Coverage

Your Spouse or Pensioned Spouse is responsible for the entire cost of COBRA Continuation Coverage and can pay for the coverage on a monthly basis. When your Spouse or Pensioned Spouse becomes entitled to this coverage, the Plan Co-Administrator will notify him or her of the COBRA premium amounts that must be paid. Individuals who continue coverage under COBRA pay 102% of the Plan's cost.

If your Spouse or Pensioned Spouse elects COBRA Continuation Coverage, he or she does not have to send any payment with the Election Form. However, the first COBRA payment must be sent to the Plan Co-Administrator not later than 45 days after COBRA Continuation Coverage is elected. (This is the date the Election Notice is post-marked, if mailed.) If your Spouse or a

Pensioned Spouse does not make the first payment for COBRA in full within this timeframe, he or she will lose all COBRA Continuation Coverage rights under the Plan.

Payments for subsequent months are due on the first day of the month for which coverage is provided. Your Spouse or Pensioned Spouse will be billed on a monthly basis for subsequent months.

## Grace Period for Payments

Although payments are due on the first day of the month, your Spouse or Pensioned Spouse will be given a grace period of thirty (30) days after the first day of the coverage period to make each payment. The COBRA Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If your Spouse or Pensioned Spouse fails to make the required payment before the end of the grace period for that coverage period, he or she will lose all rights to COBRA Continuation Coverage under the Plan.

## Notice of Unavailability of COBRA Continuation Coverage

In the event the Plan is notified of a Qualifying Event, but the Plan Co-Administrator determines that your Spouse or Pensioned Spouse is not entitled to the requested COBRA Continuation Coverage, he or she will be sent an explanation indicating why the COBRA Continuation Coverage is not available. This notice of the unavailability of the COBRA Continuation Coverage will be sent according to the same timeframe as a COBRA election notice.

## Early Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- All required payments are not made on time;
- The person receiving the coverage becomes covered by another group health plan;
- The Plan is terminated.
- The Employer that employed you prior to the Qualifying Event has stopped contributing to this Plan, but is making group health plan coverage available through another health plan. Your Spouse or Pensioned Spouse should contact your former Employer to determine whether it will assume his or her COBRA Continuation Coverage.

COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant not receiving continuation coverage (such as fraud). Once COBRA Continuation Coverage terminates, it cannot be reinstated.

## Notice of Early Termination of COBRA Continuation Coverage

The Plan Co-Administrator will notify your Spouse or Pensioned Spouse if COBRA Continuation Coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA Continuation Coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period and the date COBRA Continuation Coverage terminated. The notice will be provided as soon as practicable after the Plan Co-Administrator determines that COBRA Continuation Coverage will terminate early.

## Confirmation of COBRA Continuation Coverage to Providers

Under certain circumstances, federal rules require the Plan to inform health care providers as to whether your Spouse or Pensioned Spouse has elected and/or paid for COBRA Continuation Coverage. This rule only applies in certain situations where the provider is requesting confirmation of coverage and your Spouse or Pensioned Spouse is eligible for, but has not yet elected, COBRA Continuation Coverage, or he or she has elected COBRA Continuation Coverage but has not yet paid for it. In these circumstances, the providers will be given the status of the election and/or payment, and will be given notice that no claims will be paid until the amounts due have been received. They also will be informed that COBRA Continuation Coverage will terminate effective as of the date of any unpaid amount if payment is not received by the end of the grace period.

## Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." You can learn more about many of these options at www.healthcare.gov.

## If You or Your Spouse Have Questions

Questions concerning the Plan or COBRA Continuation Coverage rights should be addressed to the Plan Co-Administrator identified below. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area of visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

## Keep the Plan Informed of Address Changes

In order to protect your Spouse's rights, you and/or your Spouse should keep the Plan Co-Administrator informed of any changes in the addresses. You should also keep a copy, for your records, of any notices you send to the Plan Co-Administrator.

## You Must Concurrently be a Qualified Beneficiary under MILA's COBRA Rules

Because the Plan's Dental Benefits, Vision Benefits, Hearing Aid Reimbursement Benefits, and Specialist Reimbursement Benefits are supplemental to the benefits provided by MILA, in order to be eligible for the Plan's COBRA Continuation Coverage you must concurrently be a Qualified Beneficiary under MILA's COBRA rules.

## Plan Contact Information

STA-ILA Benefits Plan
ATTN: Plan Co-Administrator
Holabird Business Park
6610 Tributary Street
Baltimore, MD 21224-6514
(410) 633-9311

# Dental Benefits

In addition to the dental benefit coverage offered by MILA through its designated Dental Benefit Manager, the Plan offers a supplemental in-network dental implant coverage that will pay the difference between the amount paid by MILA's designated Dental Benefit Manager, if any, and the actual cost of the in-network service, up to a maximum allowance of $1,000 per year. You have the option of using an in-network dental provider designated by MILA's Dental Benefit Manager, or an out-of-network dental provider; however, your out-of-pocket expenses may be lower if you use an in-network dental provider.

If you use an in-network dental provider, you will be eligible for this covered dental implant service, taking into account the benefits received through MILA's designated Dental Benefit Manager. In some instances, MILA's designated Dental Benefit Manager may provide the added implant benefit in addition to MILA's basic dental benefit, and then invoice the Plan (but not you) for the difference. In instances where MILA's designated Dental Benefit Manager provides only the basic level of MILA's dental benefit, this Plan will then reimburse you for the difference, if any, between the amount of the in-network dental benefit payable by MILA's designated Dental Benefit Manager and the benefit amount that otherwise is payable by this Plan.

In order to receive a reimbursement from the Plan, you or your provider must first submit your claim to MILA's designated Dental Benefit Manager. You may then submit a claim for the difference in benefits to the Fund Office, which must be accompanied with an Explanation of Benefits from MILA's designated Dental Benefit Manager indicating the amount paid by MILA's designated Dental Benefit Manager or the reason for rejection of the claim and proof of payment to the provider. The Fund Office will then consider your claim for supplemental payment and will reimburse you to the extent that your claim is approved. All reimbursement requests must be submitted to the Fund Office within one year of the date of the Explanation of Benefits or claim denial.

If you use an out-of-network dental provider, you will not be eligible for reimbursement from the Plan's Fund Office.

## Limitations

- Covered services must be performed by or under the supervision of a dentist, within the scope of practice;

- If you switch dentists during a course of treatment, or if more than one dentist renders services for the implant procedure, Dental Benefits shall be limited as if only one dentist rendered the service;

- Dental Benefits will be paid only after all implant procedures have been completed.

- The Dental Benefit covers the use of implants that are FDA-approved and ADA-acceptable. In addition to the surgical implant procedure, this allowance will also cover subsequent maintenance visits as required, as well as cleanings and repair and/or replacement of screws or attachments.

- Dental Benefits are subject to the Subrogation/Indemnification provisions described in the SPD.

The Plan covers in-network services, only to the extent that it provides a higher benefit amount for a covered service than MILA's designated Dental Benefit Manager.

## Exclusions

- Replacement of an implant that is determine to be satisfactory or repairable;

- Replacement of implants within five years from the date of placement or replacement for which benefits were paid in whole or in part by the Plan;

- Appliance or restorations needed in completed reconstruction where natural teeth are present to increase vertical dimension;

- Dental services mainly for cosmetic reasons; exception: benefits will be provided for trauma, to whole sound natural teeth;

- Prescription drugs.

Other examples of benefits not covered are benefits provided under Titles XVIII and XIX of the Social Security Act, under any workers' compensation or occupational disease act or law, under any employers' liability law, or under any other legislation having a similar purpose, regardless of whether a Participant elects to claim such benefits, or to the extent that the cost of such dental care may be recovered in any action at law and in compromise settlement of such claims against any party other than the insured.

# Vision Care Benefits

The Plan offers supplemental vision coverage to Participants in addition to the vision benefit coverage offered by MILA through its designated Vision Benefit Manager. The Plan will pay the difference between the amount paid by MILA's designated Vision Benefit Manager, if any, and the actual cost of the in-network service, up to the maximum benefit payable by the Plan for the covered in-network service. You have the option of using an in-network vision provider designated by MILA's Vision Benefit Manager, or an out-of-network vision provider; however, your out-of-pocket expenses may be lower if you use an in-network vision provider.

If you use an in-network vision provider, you will be eligible for covered vision services at a benefit level no less than the amount shown in the Benefit Schedule, taking into account the benefits received through MILA's designated Vision Benefit Manager. In some instances, MILA's designated Vision Benefit Manager may provide the added benefit in addition to MILA's basic vision benefit, and then invoice the Plan (but not you) for the difference. In instances where MILA's designated Vision Benefit Manager provides only the basic level of MILA's vision benefit, this Plan will then reimburse you for the difference, if any, between the amount of the in-network vision benefit payable by MILA's designated Vision Benefit Manager and the benefit amount that otherwise is payable by this Plan.

In order to receive a reimbursement from the Plan, you or your provider must first submit your claim to MILA's designated Vision Benefit Manager. You may then submit a claim for the difference in benefits to the Fund Office, which must be accompanied with an Explanation of Benefits from MILA's designated Vision Benefit Manager indicating the amount paid by MILA's designated Vision Benefit Manager or the reason for rejection of the claim and proof of payment to the provider. The Fund Office will then consider your claim for supplemental payment and will reimburse you to the extent that your claim is approved. All reimbursement requests must be submitted to the Fund Office within one year of the date of the Explanation of Benefits or claim denial.

If you use an out-of-network vision provider, you will not be eligible for reimbursement from the Plan's Fund Office.

## Limitations

- Vision care expenses are covered if they are provided by an ophthalmologist, optometrist, or optician. Such person must be properly licensed in the state where the services or supplies are provided and be acting within the scope of his license.

- The Plan covers one eye exam, one set of prescription single vision or standard multi-focal lenses, and one set of select frames in each one-year period for each covered person. The Plan also covers one set of contact lenses (in place of one set of lenses and frames) per year. In addition, the Plan covers two sets of lenses for cataract care within two years of a diagnosis of cataracts.

- The Plan covers in-network services, only to the extent that it provides a higher benefit amount for a covered service than MILA's designated Dental Benefit Manager.

- Vision Care Benefits are subject to the Subrogation/Indemnification provisions described in the SPD.

## Exclusions

Vision Care Benefits are not payable under any of the circumstances listed in the General Exclusions section of the SPD or if such benefits are covered under any other Section of the Summary Plan Description. Also, benefits are not payable for:

- Replacement of lost lenses and/or frames;

- Medical or surgical treatment for eye disease which require the services of a Physician;

- Non-prescription sunglasses;

- Non-prescription goggles (goggles covered under the frame allowance); or

- Services and supplies paid for by any other group insurance program.

No payment is made for medical or surgical treatments; drugs or medications; non-prescription lenses; two pair of glasses in lieu of bifocals; subnormal visual aids; vision examination or materials required for employment; replacement of lost, stolen, broken, or damaged lenses, contact lenses or frames, except at normal intervals when service would otherwise be available; services or materials provided by Federal, State, local government, or worker's compensation; examination, procedures training, or materials not listed as a covered service; industrial safety lenses and safety frames, with or without side shields; parts or repair of frame.

# Hearing Aid Reimbursement Benefit

## In General

The Plan pays for the purchase and fitting of one hearing aid for each ear once every three years, up to 80% of the first $2,000 per hearing aid. In order to be initially eligible for this benefit, the participant must produce a statement from a physician confirming the necessity for a hearing aid.

## Coordination with MILA

All Hearing Aid Reimbursement Benefit claims must first be submitted to MILA's designated Hearing Aid Benefit Manager. This Plan will pay the difference, if any, between the amount of Hearing Aid Reimbursement Benefit payable by MILA's designated Hearing Aid Benefit Manager and the benefit amount that otherwise would have been payable by this Plan.

For example, if this Plan would have paid $1,550 for a covered hearing aid service and MILA's designated Hearing Aid Benefit Manager provides a benefit of $1,500 for the service, then this Plan will pay a benefit of $50. Conversely, if MILA's designated Hearing Aid Benefit Manager would have provided a benefit of $1,000 and this Plan provides $800 for that service, then there would be no benefit payable by this Plan.

Any request for benefits from this Plan must be accompanied with an Explanation of Benefits from MILA's designated Hearing Aid Benefit Manager indicating the amount paid by MILA's designated Hearing Aid Benefit Manager or the reason for rejection of the claim.

## Limitations

Hearing Aid Reimbursement Benefits are not payable under any of the circumstances listed in the General Exclusions section of this Summary Plan Description ("SPD"). In addition, benefits are not payable for:

- Batteries;
- Repair of hearing aids; and
- Expenses that are covered under any other Section of the Summary Plan Description.

# Specialist Reimbursement Account

The Plan will reimburse you and your Spouse or Pensioned Spouse for a portion of the co-payment amounts you incur while visiting a "specialist" Physician through your medical coverage with the Management-International Longshoremen's Association Managed Health Care Trust Fund (MILA).

The Plan will reimburse you up to $15.00 of this co-payment amount, up to a maximum of $360.00 per Calendar Year, per covered person. In order to receive reimbursement, you must submit your receipts and your Explanation of Benefits (EOB) to the Fund Office. The receipt or EOB must clearly indicate a description and date(s) of services provided, the provider's name and address, and the amount you paid to the provider. The medical service must also be considered a covered specialist claim under the MILA Fund.

In order for your specialist visits to be reimbursed, the services must have been incurred during the Calendar Year for which you are seeking reimbursement. Eligible expenses will be considered incurred on the date of the specialist visit. All eligible expenses must be submitted for payment by March 31st of the Calendar Year following the Calendar Year in which services were provided.

# Life Insurance Benefits

## Payment of Life Insurance Benefit

The Plan has contracted with an insurance company to pay a Life Insurance Benefit in the amount shown in the Benefit Schedule on page 46 to your beneficiary if you die from any cause while covered by the Plan. If your beneficiary dies before you or if you fail to name a beneficiary, the Life Insurance Benefit is paid to your estate. If your beneficiary is a minor, the Life Insurance Benefit is paid according to the rules established by the insurance company.

## Designation of Beneficiary

When you enroll in the Plan, you will be asked to name a beneficiary. You may name more than one beneficiary to receive your Life Insurance Benefit, and you may change your designation at any time by filing a form with the Fund Office.

## Conversion Privilege

If an individual's Life Insurance Benefit, or any portion thereof, terminates, he or she is entitled to convert all or a portion of the Amount of Insurance which has been terminated. This conversion will be to an individual policy of life insurance ("Conversion Policy"). The individual will not be required to submit evidence of insurability to convert.

## Conversion Rights

If your Life Insurance Benefit, or any portion thereof, terminates because you cease to be eligible or are transferred from one Class another, and the Class to which you are transferred provides lesser benefits, you may convert up to the Amount of Insurance which terminated, less any amount for which you become eligible under the Life Insurance Benefit or under any other group policy within 31 days from the date of termination. If your Life Insurance Benefit is reduced because of age or retirement, you may convert up to the amount of the reduction. If your Life Insurance Benefit terminates because this Policy terminates, or is amended to terminate coverage for a Class under which you were insured, you may convert to an amount that does not exceed the lesser of the following, provided you have been continuously insured under the Life Insurance Benefit for at least five (5) years:

- the amount of Life Insurance Benefit in effect on the date of termination, less any amount for which you become eligible under this Policy or any other group policy (which replaces this Policy) within 31 days after the date of termination; or

- $10,000.

## Notice of Conversion Privilege

The Plan will notify you of your right to convert. If the notice is not given by the 16th day of the 31-day Conversion Period, you will have an additional period in which to convert. The additional period will expire 15 days from the date you are notified, but in no event will the right to convert be extended more than 91 days beyond the date your insurance terminated. Written notice presented to you, or mailed to your last known address, shall constitute notice for purposes of this provision. In no event is your Life Insurance Benefit extended beyond the end of the 31-day Conversion Period, whether or not notice is given.

## Conversion Period, Conversion Policy, Premium, and Effective Dates

To qualify for a Conversion Policy, you must submit a written application to the life insurance company and pay the first premium due within 31 days from the date your Life Insurance Benefit terminates, unless an additional period in which to convert has been granted as shown in Notice of Conversion Privilege subsection, above.

You may convert to any individual policy that is then being offered by the life insurance company, other than term insurance, or insurance that provides disability or other supplemental benefits.

The premium rates for the Conversion Policy will be the life insurance company's premium rates in effect for the amount and type of policy elected and based on the individual's class of risk and attained age (age nearest birthday at the date of issue of the Conversion Policy) on the effective date of the Conversion Policy. The individual life insurance Conversion Policy will take effect at the end of the 31-day period provided the premium has been paid before the end of such period.

## Death Within the Conversion Period

If you die during the 31-day Conversion Period, the maximum Life Insurance Benefit that you were entitled to convert will be paid as a benefit under this Policy, to the last Beneficiary named, whether or not conversion was applied for, and premium paid. If a Conversion Policy was applied for, such Conversion Policy will be null and void even if the Conversion Policy had been issued; and no death claim will be payable under the Conversion Policy. The life insurance company will return any premium paid for the Conversion Policy.

# Dependent Spouse Death Benefit

If your Dependent Spouse dies while you are covered by the Plan, you will be paid a Death Benefit in the amount shown in the Benefit Schedule on page 46. The Plan has contracted with an insurance company to pay the Death Benefit for your Spouse, in the amount shown in the Benefit Schedule. To receive the Death Benefit described in this paragraph, your Spouse's name must be on file at the Fund Office.

# Burial Benefits

## Pensioned Spouse's Burial Benefit

If a Pensioned Spouse dies while receiving benefits from the Pension Plan, this Plan pays up to $5,000 toward burial or cremation expenses. In order to be eligible for this benefit, the deceased Pensioner must have earned at least twenty (20) years of Vesting Service while working in Covered Employment. Generally, a Pensioner would have received one year of Vesting Service for each Plan Year in which the Pensioner, prior to retirement, worked at least 1,000 hours in Covered Employment.

This payment is made only to those individuals who incur expenses in connection with the burial or cremation of a Pensioned Spouse. If no one has incurred burial or cremation expenses and a claim from the funeral director is outstanding, payment will be made to a funeral home or crematory, whichever applicable. If Burial Benefits have been paid in advance by or on behalf of the Pensioned Spouse, the benefits will be paid to his or her estate. Benefits are not payable unless the Fund Office receives a claim for payment within one (1) year of the date of the Pensioned Spouse's death. This benefit is self-funded by the Plan.

# General Exclusions

In addition to the specific exclusions listed in the various sections, the Plan does not provide benefits for expenses for or in connection with:

- Occupational Injuries or Illness for which you are eligible to receive benefits from any workers' compensation or similar law;
- Medical services or supplies provided or paid by any federal, state, or local governmental agency or program, except as may be required by law;
- Conditions caused by or arising out of an act of war or aggression, whether declared or not, or a conflict involving the armed forces;
- Conditions that are not treated by a Physician or a licensed Provider;
- Services or supplies that are not Medically Necessary for the treatment of an Injury or Illness;
- Services that would not have been provided if coverage did not exist or for which you or your Spouse are not required to pay;
- Custodial care or care received in a nursing home;
- Commission, as a perpetrator, of a felony, misdemeanor, or other criminal activity;
- Participation in a riot;
- Travel and lodging, whether or not recommended by a Physician;
- Failure to appear for a scheduled appointment or to provide claim forms or documents;
- Injuries or Illnesses that result from or occur because of your employment for wage or profit in an occupation that is not covered under this Plan;
- Charges for services or supplies that are not recommended and approved by a Physician; or
- Any other services or supplies that are not shown as being covered under this Plan.

# Coordination of Benefits

## In General

The benefits payable to you under this Plan are "coordinated" with any benefits payable to you, your Spouse, or a Pensioned Spouse for the same expenses from other group health plans.

Coordination of benefits or "COB" means that benefits payable from this Plan and from other insurance plans can equal but not exceed 100% of allowable expenses. This permits the actual expenses to be paid in full, up to certain allowable amounts, without duplicating the benefits. Coordination also establishes the priority of payment among group health plans.

"Allowable expenses" are any charges for benefits and services covered in full or in part under this Plan and any other plan under which the person making the claim is covered.

The following rules, in this order, determine whether a plan is considered primary or secondary:

- The plan that does not contain a COB provision is the primary plan and this Plan will be the secondary plan.

- The plan covering someone other than as a dependent (e.g. as an employee or retiree) is the primary plan; and the plan covering that person as a dependent is the secondary plan.

- The plan covering a person as a laid-off employee, or retiree, or a dependent of such person, pays benefits after any other plan covering the person as an active employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the provisions under Section (2) above can determine the order of benefits.

- If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the plan covering the person as an employee or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the provisions under Section (2) above can determine the order of benefits.

- The plan that has covered the employee or retiree for a longer period is the primary plan, and the plan that has covered the employee or retiree for a shorter period of time is the secondary plan.

- If a priority still is not established, the allowable expenses will be shared equally between the plans. The maximum amount payable under this Plan is the amount that would have been payable if this Plan was the primary plan.

If two plans are both secondary, the rules shown above are repeated until one plan is shown to be primary. Benefits are paid under a secondary plan only to the extent that they are not payable under any other plan.

If the primary plan is a Health Maintenance Organization (HMO), and your Spouse fails to use the designated physician, institution or facility, this Plan will exclude from payment services that would have been provided by the HMO.

If you are covered by both this Plan and Medicaid, this Plan is the primary plan and Medicaid is the secondary plan.

If you are covered by both this Plan and any other coverage (not already mentioned above) that is provided by another state or federal law, the coverage provided by another state or federal law pays first and this Plan pays second.

## COB with Medicare for Retirees

If you are eligible for retiree coverage and become eligible for Medicare, Medicare will be the primary plan and this Plan will be the secondary plan. All medical claims after your enrollment in Medicare must be submitted to Medicare first. After Medicare pays the claim, submit a copy of the bill along with the Medicare Explanation of Benefits to the claims address shown on the back of your Identification Card. After deducting the amount paid by Medicare, the Plan will pay benefits based on the remaining balance. You must pay any applicable Deductible whether or not the medical services provided are covered or not covered by Medicare.

Federal law limits the amount a provider (such as a hospital or physician) can charge above the Medicare payment. The Plan cannot pay the provider more than that amount and the provider cannot legally bill you more than that amount.

This Plan will not pay benefits for any health care services and/or supplies received pursuant to a private contract with certain health care practitioners that agree not to submit claims to, or receive any payments from, Medicare.

Contact the Fund Office if you would like to know more about coordination of benefits.

# Claims Procedures

To ensure the prompt payment of a claim for benefits, please keep a detailed record of all covered expenses incurred by you, your Spouse, or a Pensioned Spouse. You should keep in mind that it might be someone else's responsibility to file a claim for benefits, for example, in the event of your death. Therefore, it is suggested that someone in addition to you read this Summary Plan Description ("SPD") and become familiar with the Plan's benefits and claims procedures.

All claims for benefits, except those for Life Insurance Benefits, are paid directly to the person or entity that provided the service or supply, unless the charges have already been paid by you, your Spouse, or a Pensioned Spouse. If you, your Spouse, or a Pensioned Spouse have already paid for the service and supply, this Plan will reimburse you or a Pensioned Spouse directly for those charges that are covered.

## What is a Claim

A "claim" is a written request on a pre-approved form from you or your authorized representative for payment of your Plan benefits made in accordance with the Plan's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a claim. However, if you file a claim for a specific benefit and your claim is denied because you are not eligible for the benefit under the Plan, the coverage determination is considered a claim.

Interactions between you and a participating provider do not constitute a claim in a case where the provider exercises no discretion on behalf of the Plan. However, if the provider declines to render service unless you pay the entire cost, you should submit a claim for the service, as described under the "Determination of a Benefit Claim" section, below.

In addition to an application for benefits under the following: Dental Benefits, Vision Care Benefits, Hearing Aid Reimbursement Benefits, and Specialist Reimbursement Account Benefits, a claim also includes a rescission of coverage of any of the above benefits whether or not there is an adverse effect on any particular benefit.

An adverse benefit determination does not include rescissions of coverage with respect to any of the following benefits: Life Insurance Benefits and Burial Benefits.

## Notice of a Claim Decision

With respect to claims for Dental Benefits, Vision Benefits, Hearing Aid Reimbursement Benefits, and Specialist Reimbursement Account Benefits, where there is an adverse

determination, the written notice of a denial of a claim will include the following information, in addition to that listed in the SPD:

- A statement of your right, upon request and free of charge, to reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

- Either the specific internal rules, guidelines, protocol, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

## Review Process

Before issuing an adverse benefit determination on appeal with respect to Dental Benefits, Vision Benefits, Hearing Aid Reimbursement Benefits, and Specialist Reimbursement Account Benefits:

- You will be provided with a reasonable opportunity to respond, by presenting written evidence and testimony, to any new or additional information.

- The Plan will automatically provide you, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim.

- The Plan will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided.

- This new or additional evidence or rationale will be provided to you so that you will have a reasonable opportunity to respond regarding the new or additional evidence or rationale, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided.

- If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond.

- After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.

## Decision of Trustees

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals, and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

To the extent required by applicable law, any notices will be provided in a culturally and linguistically appropriate manner.

## Filing a Claim

Claims must be submitted in writing on pre-approved forms. A completed claim form usually contains the necessary proof of claim, but sometimes additional information or records may be required. The claim form must be completed in full for each family member, including all information and statements from the providers of service. Be sure that you properly sign each form.

Your claim for benefits will be considered for payment upon the receipt of a completed claim form by the appropriate party responsible for determining the initial determination of the claim as indicated below:

Contact the Fund Office at (410) 633-9311 to obtain claim forms for the following benefits:

- Dental Benefits;
- Vision Care Benefits;
- Life Insurance Benefits; and/or
- Burial Benefits.

File your completed claim form with the Fund Office at:

STA-ILA Benefits Plan
Holabird Business Park
6610 Tributary Street
Baltimore, MD 21224-6514
or by facsimile at (410) 633-9347

No claim forms are required for Hearing Aid Reimbursement Benefits or Specialist Reimbursement Account Benefits.

## Filing Deadlines

Certain filing deadlines must be met in order to ensure that your claims are paid.

- Life Insurance and Burial Benefits. In case of claims for Life Insurance Benefits, proof of loss must be furnished to the Fund Office within one (1) year after the date of loss.

- All Other Benefits. In general, claims shall be considered for payment upon receipt within ninety (90) calendar days from the date the service or supply is provided. However, a claim shall not be considered for payment after one (1) year from the date the service or supply is provided.

The Trustees for good cause may waive a filing deadline on a non-precedent basis.

## Right to an Authorized Representative

If you wish, you can appoint an authorized representative to act on your behalf for the purposes of filing a claim and seeking a review of a denied claim. You also can simply choose to represent yourself. In order to use an authorized representative (this person may be an attorney, but need not be), however, you must notify the Fund Office in advance, by completing and submitting a designated form. Contact the Fund Office to obtain a form to appoint an authorized representative.

## Determination of a Benefit Claim

The determinations of benefit claims will vary depending on the type of claim. The period of time for the Plan to make a benefit determination begins at the time the claim is filed in accordance with the Plan's procedures, without regard to whether all the necessary information accompanies the filing. Please read each section carefully to determine which procedure is applicable to your request for benefits.

- **Hearing Aid Reimbursement and Specialist Reimbursement Benefit.**

  No claim forms are required for Hearing Aid Reimbursement Benefits or Specialist Reimbursement Account Benefits. Contact the Fund Office to submit requests for reimbursement of Hearing Aid Reimbursement Benefits or Specialist Reimbursement Account Benefits.

  File your request for reimbursement with the Fund Office at:

  STA-ILA Benefits Plan
  Holabird Business Park
  6610 Tributary Street
  Baltimore, MD 21224-6514
  or by facsimile at (410) 633-9347

If your request for a Hearing Aid Reimbursement Benefit is denied, in whole or part, you will receive a written notice of the denial within 30 calendar days from the receipt of the request. The Plan may extend this period one time for up to 15 calendar days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which a benefit determination is expected to be rendered.

If an extension is required because the Plan needs additional information from you, the extension notice will specify the information needed. You will have *45 calendar days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your request will be denied. During the *45-day* period in which you are allowed to supply additional information, the normal deadline for making a decision on the request will be suspended. The deadline is suspended from the date of the extension notice until either *45 calendar days* or until the *date you respond to the request*, whichever is earlier. The Plan then has *15 calendar days* to make a decision on the request and notify you of the determination.

- **Life Insurance and Burial Benefits.**

  If your claim for a death Life Insurance Benefit or Burial Benefit is denied, in whole or part, you will receive a written notice of the denial within 90 calendar days after your claim has been received. Should special circumstances require additional time to decide your claim, you will be provide with a written notice of the extension within 90 calendar days after receipt of your claim explaining the special circumstances and the date by which a benefit determination is expected to be rendered. This extended due date cannot exceed 180 calendar days from the date on which your claim originally was filed (in other words, the extension itself cannot exceed 90 calendar days).

If an extension is required because the Plan needs additional information from you, the extension notice will specify the information needed. You will have *45 calendar days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the *45-day* period in which you are allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either *45 calendar days* or until the *date you respond to the request*, whichever is earlier.

## Notice of a Claim Decision

If your claim is denied, in whole or in part, you will be provided with written notice of a denial of a claim. This notice will state:

- The specific reason(s) for the determination.

- Reference to the specific Plan provision(s) on which the determination is based.

- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.

- A description of the appeal procedures and applicable time limits.

- A statement of your right to bring a civil action under the Employee Retirement Income Security Act ("ERISA") Section 502(a) following an adverse benefit determination on review.

With respect to claims other than for Life Insurance Benefits and Burial Benefits:

- If an internal rule, guideline, or protocol was relied upon in deciding your claim, you will receive a statement that the rule is available upon request at no charge.

- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive a statement that the explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim is available upon request at no charge.

## Request for a Review of Denied Claim - Appeal Procedures

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you or your authorized representative may ask for the claim to be reviewed. All appeals must be made in writing to the Board of Trustees and submitted to the Fund Office.

- Dental Benefits, Vision Care Benefits, Hearing Aid Reimbursement Benefits, and Specialist Reimbursement Account Benefit Claims. You have 180 calendar days from the day you received notice of the initial decision to appeal the claim.

- Life Insurance and Burial Benefit Claims. You have sixty (60) calendar days from the day you received notice of the initial decision to appeal the claim.

## Review Process

You have the right, upon request and free of charge, to receive reasonable access to and copies of all documents “relevant” to your claim. A document, record or other information is relevant if:

- it was relied upon in making the decision;

- it was submitted, considered, or generated in the course of making the benefit determination (regardless of whether it was relied upon);

- it demonstrates compliance with the administrative processes for ensuring consistent decision making; or

- with respect to claims other than for Life Insurance Benefit and Burial Benefit claims, it constitutes a statement of Plan policy regarding the denied treatment or service.

The review will take into account all comments, documents, records and other information you submit relating to the claim (regardless of whether this information was submitted or considered in the initial benefit determination).

With respect to claims other than Life Insurance Benefit or Burial Benefit claims:

- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the organization responsible for the initial determination of your claim, without regard to whether their advice was relied upon in deciding your claim.

- A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

- If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

## Timing of Notification of Decision on Appeal

Ordinarily, decisions on appeals involving all other claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within thirty (30) calendar days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five (5) calendar days after the decision has been reached.

## Notice of a Decision on Review of Appeal

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination;

- Reference to the specific Plan provision(s) on which the determination is based;

- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;

- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

With respect to claims other than Life Insurance Benefit or Burial Benefit claims, you will also receive a statement indicating the following, if applicable:

- If an internal rule, guideline or protocol was relied upon by the Plan, a copy of such rule, guideline or protocol will be provided upon request at no charge;

- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment used in the determination of your claim will be provided upon request at no charge.

## Decision of Trustees

The denial of an application or claim to which the right of review has been waived or the decision of the Trustees, or its designees with respect to a petition for review, shall be final and binding upon all parties, including the applicant, claimant, or petitioner and any person claiming under the application, claimant, or petitioner, subject only to judicial review. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "Participant" or "Beneficiary" of the Plan within the meaning of those terms as defined in ERISA.

## Limitation on When a Lawsuit may be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the ERISA without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than one (1) year after the end of the year in which services were provided, or more than one (1) year after the date of death.

# Administration of Your Benefit Plan

This section provides information that you may find useful whenever you have questions about your Plan. It contains names and addresses of people and organizations you may need to contact.

## Name of Plan

STA-ILA Benefits Plan for Pensioners

## Plan Identification Numbers

EIN: 52-0575721
Plan Number: 501

## Plan Year

October 1 through September 30

## Type of Plan

An employee welfare benefit plan providing Dental Benefits, Vision Care Benefits, Hearing Aid Reimbursement Benefits, Specialist Reimbursement Account Benefits, Life Insurance Benefits, and Burial Benefits.

## Plan Sponsor

The Board of Trustees of the STA-ILA Benefits Trust Fund. All communications to the Plan Sponsor should be sent to:

Board of Trustees
STA-ILA Benefits Trust Fund
Holabird Business Park
6610 Tributary Street
Baltimore, MD 21224-6514

A complete list of Employers and Unions sponsoring the Plan may be obtained upon written request to the Plan Co-Administrator, and is available for examination. In addition, you may receive from the Plan Co-Administrator, upon written request, information as to whether a particular Employer or employee organization is a plan sponsor, and if so, the sponsor's address.

## Plan Administrator/Fund Office

Board of Trustees
c/o Richard P. Krueger III, Co-Administrator
Richard P. Wohlfort, Jr., Co-Administrator
STA-ILA Benefits Trust Fund
Holabird Business Park
6610 Tributary Street
Baltimore, Maryland 21224-6514
Telephone: (410) 633-9311

## Agent for Service of Legal Process

The Co-Administrators of the Fund, Richard P. Krueger III and Richard P. Wohlfort, Jr. have been designated as the agent for the service of legal process and may be served at the Fund Office. Service of legal process may be upon either of the Co-Administrators or upon a Plan Trustee.

## Plan Administration, Sources of Contributions, and Funding

The Board of Trustees of the STA-ILA Benefits Trust Fund administers the day-to-day operations of the Plan. The Board of Trustees is made up of members designated by the Association whose Employer-members contribute to the Fund and members designated by the Union. The Employer and Union members, as entities, have an equal vote on all matters regardless of the number of members in attendance at a particular Board of Trustees meeting. The Board of Trustees can alter the terms, conditions, or benefits of the Plan, and makes all decisions regarding interpretations and the application of any Plan provisions. The Board of Trustees has the exclusive power to interpret the provisions of the Plan.

Contributions to the Plan are made by Employers who are obligated to contribute to the Fund in accordance with either a Collective Bargaining Agreement or a Benefits Fund Participation Agreement. The contributions are based on the number of hours paid to Employees of contributing organizations.

All benefits under the Plan are self-funded except the Life Insurance Benefit, which is insured by The Hartford Life and Accident Insurance Company. Plan assets are held and accumulated in the STA-ILA Benefits Trust Fund. Plan benefits are payable from the Trust Fund.

## Collective Bargaining Agreements

The Plan is maintained pursuant to one or more Collective Bargaining Agreements. Copies of the Agreements may be obtained by Participants upon written request to the Plan Co-Administrator and are available within thirty (30) calendar days after written request is received and directed to the Plan Co-Administrator.

## Summary Annual Report and Plan Changes

You will receive a free summary of the Plan's annual report once each year. You will be notified if any modifications are made to the Plan.

## Discretionary Authority of the Board of Trustees and its Designees

In carrying out their responsibilities under the Plan, the Board of Trustees has full and exclusive discretionary authority construe and interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination by the Board of Trustees is final and binding upon any person claiming benefits under the Plan.

## Amendment or Termination of the Plan

Neither this Plan nor any of its benefits are guaranteed. Although the Plan is intended to be permanent, the Board of Trustees reserves the right at any time to amend, change, or terminate the Plan, in whole or in part, as it finds necessary. The nature and amount of Plan benefits always are subject to the actual terms of the Plan as it exists at the time the claim occurs.

## No Liability for the Practice of Medicine

The Fund, the Plan, the Board of Trustees and their designees are not engaged in the practice of medicine and have no control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care providers. You should select a provider or course of treatment based on all appropriate facts, only one of which should be coverage by the Plan. Neither the Plan, the Plan Co-Administrator, nor any of its designees will have any liability whatsoever for any loss of injury caused by you or your health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

## Right of Recovery

If you or your Spouse files a false claim or receives payment from the Plan as a result of a mistake on your part or the Plan's part, you must make immediate repayment to the Plan upon request. Failure to make full reimbursement within 30 days of the date of the Plan's request may result in the following:

- Interest added to the amount due at the court established legal rate of interest in Maryland;
- Future benefits offset by claims filed by you, your Spouse, or Pensioned Spouse until such time as the amount the Plan would have paid out in benefit payments completely offsets the amount that is due to be reimbursed to the Plan;
- A lawsuit filed against you to recover the overpayment (including interest), court costs and attorney's fees;

- If you, your Spouse, or a Pensioned Spouse files a false claim or receives payment from the Plan through misrepresentation, in addition to the penalties listed previously, you, your Spouse or a Pensioned Spouse may be denied future coverage under this Plan; and

- The Fund Office may also notify the proper legal authorities if it appears that you, your Spouse, or a Pensioned Spouse has submitted falsified information to the Plan.

## Privacy, Confidentiality, Release of Records or Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that the Plan protect the confidentiality of your private health information. The Plan maintains a Notice of Privacy Practices that provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, please contact the Fund Office. This summary is not intended and cannot be construed as the Plan's Notice of Privacy Practices. In the event of any inconsistency between this summary and the Notice of Privacy Practices, the terms of the Notice control.

The Plan and the Board of Trustees will not use or further disclose information that is protected by HIPAA (known as "protected health information" or "PHI") except as necessary for treatment, payment, healthcare operations, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities called, "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that organization.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

If you have questions about the privacy of your health information, or if you wish to file a privacy violation complaint, please contact the Plan's Privacy Official at the Fund Office address located in the front of this Summary Plan Description ("SPD").

## Named Fiduciary Under ERISA

The named fiduciary under the Plan is the Board of Trustees.

## No Assignment of Benefits

You may not assign your benefits under the Plan, except that you may direct that benefits payable to you be paid to an institution or provider of medical care. However, the Plan is not legally obligated to accept such a direction from you, and no payment by the Plan to a provider can be considered to be a recognition by the Plan that it has a legal duty to pay the provider, except to the extent that it chooses to do so.

## Governing Law

This Plan is created and accepted in the State of Maryland and all questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Maryland except to the extent preempted by federal law.

## Savings Clause

Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect other provisions of this Plan or the application of any provisions to any other person or instance unless such illegality shall make impossible the functioning of this Plan.

## Titles

The title of any Article, Section, or provision of this Plan is for convenience and reference only and is not to be considered in interpreting the terms and conditions of this Plan.

## Construction of Words

Any words used in this Plan in the masculine gender shall be construed as though they also are used in the feminine gender in all situations where they would so apply. Any words used in this Plan in the singular form shall be construed as though they also are used in the plural form in all situations where they would so apply, and vice-versa.

# Your ERISA Rights

As a Participant in the STA-ILA Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan Participants shall be entitled to:

- Receive information about your Plan and benefits.

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Co-Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Co-Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Co-Administrator is required by law to furnish each Participant with a copy of this summary annual report.

- Continue health care coverage for your Spouse or a Pensioned Spouse if there is a loss of coverage under the Plan as a result of a qualifying event. These individuals may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union,, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan, and do not receive

them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Co-Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Co-Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting your administrative remedies by appealing the matter to the Board of Trustees. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Co-Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Co-Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# Benefit Schedule

| Benefit | Amount |
|---|---|
| Dental Benefit – In-Network (No Out-of-Network Benefits) | MILA's primary coverage amounts are subtracted from the Plan's obligation. |
| Dental implant coverage | Plan pays up to $1,000 per year. |
| Vision Care Benefit – In-Network (No Out-of-Network Benefits) | MILA's primary coverage amounts are subtracted from the Plan's obligation. |
| Examination (one exam every 12 months) | Plan pays 100%. |
| Two ophthalmologic exams within two years of a diagnosis of cataracts | Plan pays 100%. |
| Frames (one pair of frames every 12 months) | Plan pays 100% up to $200. |
| Standard plastic lenses (one set of lenses every 12 months) | Plan pays 100% up to $300 above the MILA basic benefit. This covers single vision, bifocal, trifocal, lenticular, or progressive lenses (standard/premium). |
| Contact lenses in lieu of frames/lenses (one set of contact lenses every 12 months, including fitting fees) | Plan pays 100% up to $200. |
| Pensioner Life Insurance Benefit | $12,000 |
| Dependent Spouse Death Benefit | $6,000 |
| Burial Benefit – Pensioned Spouses Only | Up to $5,000 |
| Hearing Aid Reimbursement Benefit (MILA's primary coverage amounts are subtracted from the Plan's obligation) | 80% of the first $2,000 per ear of Covered Expenses for each 3-year benefit period |
| Specialist Reimbursement Account | Up to $15 per visit, up to a Calendar Year maximum of $360.00 per covered person |

STA-ILA BENEFITS PLAN
FOR PENSIONERS
Holabird Business Park
6610 Tributary Street
Baltimore, Maryland 21224-6514
(410) 633-9311
**www.stailafunds.com**

## BOARD OF TRUSTEES – UNION

Richard P. Krueger, Jr.
ILA-ACD Vice President
6610-B Tributary Street
Suite 209
Baltimore, MD 21224-6514

Scott Cowan
ILA Vice President
6610-B Tributary Street
Suite 209
Baltimore, MD 21224-6514

Michael Coe
ILA Local 333
6610-B Tributary Street
Suite 300
Baltimore, MD 21224-6514

Michael Cross
ILA Local 333
6610-B Tributary Street
Suite 300
Baltimore, MD 21224-6514

Timothy Krajewski
ILA Local 333
6610-B Tributary Street
Suite 300
Baltimore, MD 21224-6514

David Konig
ILA Local 953
1521 E. Fort Avenue
Baltimore, MD 21230-5217

John Shade
ILA Local 953
1521 E. Fort Avenue
Baltimore, MD 21230-5217

Troy Nilson
ILA Local 1429
1128 Hull Street
Baltimore, MD 21230-5237

Christopher Kimble
ILA Local 1429
1128 Hull Street
Baltimore, MD 21230-5237

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FOR PENSIONERS
Holabird Business Park
6610 Tributary Street
Baltimore, Maryland 21224-6514
(410) 633-9311

**BOARD OF TRUSTEES – EMPLOYER**

Morgan Bailey
Tartan Terminals, Inc.
South Locust Point Terminal
2001 E. McComas Street
Baltimore, MD 21230-5018

Mauro Dal Bo
Mediterranean Shipping Co. (USA) Inc.
2200 Broening Highway
Suite 260
Baltimore, MD 21224-6620

Bayard Hogans
Ports America Chesapeake, LLC
2200 Broening Highway
Suite 100
Baltimore, MD 21224-6620

David P. Hartman
STA of Baltimore, Inc.
8615 Ridgelys Choice Drive
Suite 202
Baltimore, MD 21236-3028

Mark Schmidt
Ports America Chesapeake, LLC
2200 Broening Highway
Suite 100
Baltimore, MD 21224-6620

Bill Wade
Ceres Marine Terminals, Inc.
2908 Childs Street
Second Floor
Baltimore, MD 21226-1020

Gregory Waidlich
Atlantic Container Lines
2700 Broening Highway
Dunmar Building South
Suite 200b
Baltimore, MD 21222-7388

Douglas Wolfe
Ceres Marine Terminals, Inc.
2908 Childs Street
Second Floor
Baltimore, MD 21226-1020

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