MARITIME ASSOCIATION – I.L.A. WELFARE FUND

GROUP BENEFITS PLAN

October 1, 2018

This booklet contains coverages for life insurance, accidental death and dismemberment and accident and sickness benefits provided and administered by the Board of Trustees of the Maritime Association – I.L.A. Welfare Fund. The benefits are provided under the Agreement of Trust for the Maritime Association – I.L.A. Welfare Fund, a trust created and maintained pursuant to section 501(c)(9) of the Internal Revenue Code of 1986, as amended. Provisions for coverages for the dental supplement and those coverages provided by MILA Managed Health Care are provided for in separate booklets.

NO PARTICIPATING EMPLOYER, EMPLOYER ASSOCIATION OR LABOR ORGANIZATION, NOR ANY INDIVIDUAL EMPLOYER THEREBY, HAS AUTHORITY TO ANSWER QUESTIONS ON BEHALF OF THE TRUST FUND AND THE PLAN.

THE TRUSTEES RESERVE THE RIGHT TO TERMINATE, SUSPEND, WITHDRAW, AMEND, OR MODIFY THE PLAN AT ANY TIME. ANY SUCH CHANGE OR TERMINATION IN BENEFITS (i) WILL BE BASED SOLELY ON THE DECISION OF THE TRUSTEES AND (ii) MAY APPLY TO ACTIVE EMPLOYEES, FUTURE RETIREES AND CURRENT RETIREES AS EITHER SEPARATE GROUPS OR AS ONE GROUP, AND ANY AND ALL ELIGIBLE DEPENDENTS.

Table of Contents

DEFINITIONS FOR THE PURPOSE OF THIS PLAN

To help you more clearly understand the group benefits program established in this book, some of the terms used in describing the program as it applies to you and your eligible dependents, if any, are defined below.

The terms "Employee" and "Employer" shall be given the definition provided for in the Trust.

ELIGIBLE PARTICIPANT CLASSES -

Class 1 Employees – Employees who have accumulated 1,000 Credit Hours but less than 1,400 Credit Hours during the previous Eligibility Year.

Class 2 Employees – Employees who have accumulated 1,400 Credit Hours but less than 1,800 Credit Hours during the previous Eligibility Year.

Class 3 Employees – Employees who have accumulated 1,800 or more Credit Hours during the previous Eligibility Year.

Class 11 Employees (New Entry) – Employees who have accumulated 1,000 or more Credit Hours during the previous Eligibility Year, but less than 3,000 total Credit Hours within a 3 year period ending with the last day of the previous Eligibility Year, have not accumulated 1,500 Credit Hours in a single Plan Year commencing on or after October 1, 2012 and did not accumulate at least 1,200 hours in the Eligibility Year commencing October 1, 2011.

Class 12 Employees (Separate Welfare) – Employees who have accumulated 1,000 or more Credit Hours during the previous Eligibility Year under a separate agreement with a lesser Welfare Fund contribution, as entered into by certain I.L.A. Locals and Employers with approval of the South Atlantic and Gulf Coast District and West Gulf Maritime Association.

RETIREE COVERAGES –

Class 1 Retirees – Employees who (1) are eligible to receive a retirement benefit based on average yearly hours of at least 1,000 Credit Hours but less than 1,400 Credit Hours and (2) satisfy the requirements as set forth in the Maritime Association – I.L.A. Pension Plan for entitlement to a disability pension or satisfying the requirements set forth in the Maritime Association – I.L.A. Pension Plan for an age pension based on a minimum of twenty years of credited service (or continuous service, if applicable, in accordance with the requirements of the Maritime Association – I.L.A. Pension Plan), regardless of whether the Employee receives the retirement benefit from the Maritime Association – I.L.A. Pension Plan or the Maritime Association – I.L.A. Retirement Plan or both based on age or disability, and (3) who have qualified for Welfare Fund coverage as an Employee within the five years immediately preceding the effective retirement date or date of death.

Class 2 Retirees - Employees who (1) are eligible to receive a retirement benefit based on average yearly hours of at least 1,400 Credit Hours but less than 1,800 Credit Hours and (2) satisfy the requirements as set forth in the Maritime Association – I.L.A. Pension Plan for entitlement to a disability pension or satisfying the requirements set forth in the Maritime

Association – I.L.A. Pension Plan for an age pension based on a minimum of twenty years of credited service (or continuous service, if applicable, in accordance with the requirements of the Maritime Association – I.L.A. Pension Plan), regardless of whether the Employee receives the retirement benefit from the Maritime Association – I.L.A. Pension Plan or the Maritime Association – I.L.A. Retirement Plan or both based on age or disability, and (3) who have qualified for Welfare Fund coverage as an Employee within the five years immediately preceding the effective retirement date or date of death.

Class 3 Retirees - Employees who (1) are eligible to receive a retirement benefit based on average yearly hours of at least 1,800 Credit Hours and (2) satisfy the requirements as set forth in the Maritime Association – I.L.A. Pension Plan for entitlement to a disability pension or satisfying the requirements set forth in the Maritime Association – I.L.A. Pension Plan for an age pension based on a minimum of twenty years of credited service (or continuous service if applicable in accordance with the requirements of the Maritime Association – I.L.A. Pension Plan), regardless of whether the Employee receives the retirement benefit from the Maritime Association – I.L.A. Pension Plan or the Maritime Association – I.L.A. Retirement Plan or both based on age or disability, and (3) who have qualified for Welfare Fund coverage as an Employee within the five years immediately preceding the effective retirement date or date of death.

Class 5 Retirees – Employees who are eligible to receive a retirement benefit based on meeting Maritime Association – I.L.A. Pension Plan Section 18 (formerly I.L.A. Locals 1525 and 1581) qualifications and who have qualified for Welfare Fund coverage as an employee within the five years immediately prior to the effective retirement date or date of death.

* Collectively, references in this Plan booklet to "Retired Employees" shall mean any of Class 1, Class 2, Class 3, and/or Class 5 Retirees.

** With respect to an Employee who worked at least one Credit Hour for either Texas Mooring, Inc. or Houston Mooring Company during the October 1, 2013 to September 30, 2014 Plan Year, such Employee's hours of service during employment with either Texas Mooring, Inc. or Houston Mooring Company shall be considered for purposes of determining whether the Employee satisfies the Credit Hours and years of credited service requirements and whether such employee would have been covered under this Welfare Plan for the five years prior to the effective retirement date as set forth in the definition of Retiree Coverages under this Plan. However, with respect to determining whether an employee retires under a local port longshore pension plan with 25 or more years of pension service, as specifically referenced in the MILA National Health Plan, the prior service crediting set forth in this paragraph shall become applicable only at such time the employee attains age 65.

DEFINITIONS FOR THE PURPOSE OF THIS PLAN

GENERAL DEFINITIONS

Benefits Year – The twelve month period beginning January 1.

Covered Loss – With respect to Accidental Death and Dismemberment benefits, shall mean the (i) loss of life; (ii) loss of a hand by complete severance at or above the wrist, (iii) loss of a foot by complete severance at or above the ankle joint; or (iv) loss of an eye, involving irrecoverable and complete loss of sight in the eye.

Credit Hours – Each hour for which an Employee is paid or entitled to payment during the Eligibility Year for which contributions are made by Contributing Employers to the Maritime Association – I.L.A. Welfare Fund pursuant to the prevailing collective bargaining agreements by and between the West Gulf Maritime Association, Inc. and the South Atlantic & Gulf Coast District of the International Longshoremen's Association, AFL-CIO. The Plan has adopted the practice that such hours are credited to the Eligibility Year in which payment is received or should have been received by the Employee for the corresponding hours.

Doctor – An individual licensed as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). The term "Doctor" shall also include any licensed or certified health care provider as required by state law, for services which are within the scope of the health care provider's license or certificate.

Eligibility Year – The twelve month period beginning with the first payroll month of October as set and established by a calendar created under the West Gulf Maritime Association payroll calendar system.

Eligibility Month – The one month period beginning with the first payroll due in a calendar month as set and established by a calendar created under the West Gulf Maritime Association payroll calendar system.

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

COVERAGE FOR YOU – WHEN YOU ARE ELIGIBLE

Active Employees (Classes 1, 2, 3, 11 and 12) – You are eligible to participate on the first day of the Benefits Year following the Eligibility Year in which you earned at least 1,000 Credit Hours provided you are an Employee for one or more Employers who are contributing to the Welfare Fund.

Retired Employees (Class 1, 2, 3, and 5 Retirees) - You are eligible to participate on the later of (1) the effective date of this Plan or (2) on the first day of the Benefits Year following the Eligibility Year in which ended you satisfied the requirements to qualify as a Retired Employee.

If you are a Retired Employee and elect to return to active employment with one or more current Employers, you will remain entitled to receive Welfare benefits for the remainder of that Benefits Year and for one additional Benefits Year if necessary. Return to active employment shall be determined either as an employee affirmatively notifying the Funds office or working sufficient hours to be considered reemployed as provided for in Section 9 of the Maritime Association – I.L.A. Pension Plan.

ELIGIBLE CLASSES AND CHANGES IN BENEFITS

Your benefits for a Benefits Year will be determined based on your Credit Hours worked during the preceding Eligibility Year. Please refer to page 1 under "Eligible Participant Classes" for the Credit Hour requirements for each class under the Plan.

Any increase in benefits due to a change in your class will become effective on the January 1st following the Eligibility Year during which the change in Credit Hours occurs. Any decrease in benefits due to a change in your class will become effective the following Eligibility Year during which the change in Credit Hours occurs, except that if you are hospitalized on that date, such decrease in benefits will not become effective until the day following the date of discharge from the Hospital.

INVOLUNTARY ACTIVE MILITARY SERVICE

In the event of involuntary active military service, coverage shall be continued for the remainder of the Benefits Year, with the Plan exclusion of coverage for service connected Illness/Injury or accidental death, and upon return from involuntary active military service, provided you return to work for an Employer within ninety days after your military service ends. Coverage at the same class under the benefit level then in effect shall be continued for the remainder of that Benefits Year and one additional year if necessary.

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

COVERAGE FOR YOUR ELIGIBLE DEPENDENTS

Your dependents may also be eligible to participate. For Plan purposes, your eligible dependents are:

- Your spouse, if you are legally married. Legal marriage includes a ceremonial marriage in which a license is issued by the state prior to the ceremony and an informal marriage which requires that a Declaration and Registration of Informal Marriage be recorded by the state which authorizes such marriage. The effective date of an informal marriage shall be the later of the date the declaration is recorded or June 30, 1976. A spouse shall no longer be covered under this Plan as of the date of divorce.

- Your unmarried, children through age 19 (unless otherwise specified), which includes the following:
  - Natural born children of a legal marriage;
  - Adopted children, including children placed with you for the purpose of adoption;
  - Children (1) that you are the legal guardian of the person and estate, as appointed by a court, (2) that reside in your home and are wholly dependent on you for support and maintenance, and (3) have no surviving parents and have not been or are in the process of being adopted by another person;
  - Step-children born of a legal marriage provided you are married to the mother or father of such child or children;
  - Any child declared to be your child by a certified court order (Order Establishing Parent Child Relationship, Acknowledgment of Paternity, or Qualified Medical Child Support Order).

Except as provided below, the term Dependent will not include any person who is eligible for coverage as an Employee.

You become eligible for Dependent coverage on the later of:
(1) the date you become eligible, if you have an eligible Dependent at that time; or (2) the date you first acquire an eligible Dependent.

Adopted children are deemed to be acquired on the date of placement with you for the purpose of adoption.

Your Dependents will be covered on the date you become eligible for Dependent coverage provided that a Dependent, other than a newborn child, who is in a hospital on the date he or she would otherwise become insured under this Policy, shall not become insured until the date he or she is finally discharged from the hospital.

REPORTING CHANGES IN ELIGIBILITY OF DEPENDENTS

YOU SHOULD NOTIFY THE WELFARE FUND OFFICE WHEN YOU ACQUIRE A DEPENDENT. ALSO, YOU MUST NOTIFY THE WELFARE FUND OFFICE WHEN A DEPENDENT IS NO LONGER ELIGIBLE. YOU WILL BE PERSONALLY RESPONSIBLE FOR ANY OVERPAYMENTS INCURRED DUE TO PAYMENTS MADE ON BEHALF OF INELIGBLE DEPENDENTS. WITH RESPECT TO ANY OVERPAYMENT, THE AMOUNTS SHALL BE RECOVERABLE REGARDLESS OF WHETHER THE FUNDS HAVE BEEN COMMINGLED WITH OTHER ASSETS AND THE PLAN MAY RECOVER FROM ANY AVAILABLE FUNDS, WITHOUT THE NEED TO TRACE THE SOURCE OF THE FUNDS AND WITHOUT REGARD TO THE SPECIFIC MONEY RECEIVED AS THE OVERPAYMENT.

WHEN COVERAGE ENDS

Your coverage will cease on the sooner of:

(a) the date the Plan ceases;
(b) the date the Plan ceases for the class of Employees to which you belong;
(c) the date you are no longer a member of the class eligible;
(d) the date ending the period for which your last contribution is made, if you are required to pay a part of the cost of the Plan;
(e) the last day of the Benefits Year if, during the preceding Eligibility Year, you accumulated less than the required Credit Hours; provided that this provision shall not apply to an Employee who satisfies the requirements to become a Retired Employee (see the Schedule of Benefits for benefits for Retired Employees and their eligible Dependents); or
(f) the date you enter active military service for 31 days or more.

Your coverage with respect to Dependents will cease on the sooner of:

(a) the date ending the period for which your last contribution is made, if you are required to pay a part of the cost of the Plan;
(b) the date your coverage ceases, except as provided below under "For Dependents of Deceased Employees";
(c) the date a Dependent ceases to be eligible as a Dependent, except as provided on the following page under "For Disabled Children";
(d) the last day of the Benefits Year if, during the preceding Eligibility Year, the Employee accumulated less than the required Credit Hours;
(e) the date the Dependent enters active military service for 31 days or more; or
(f) the date that adoption proceedings are discontinued provided that such proceedings do not result in finalization of the adoption.

TERMINATED VESTED PARTICIPANTS

Terminated Vested Participants with a minimum of twenty years of Credited Service as determined under the terms and conditions of the Maritime Association – I.L.A. Pension Plan (regardless of whether the participant has an interest in the Pension Plan) who have not qualified for Welfare Fund coverage within each of the five years immediately prior to an effective retirement date will not regain eligibility under the Maritime Association – I.L.A. Welfare Plan at the date of retirement. This provision will also be applicable to an eligible surviving spouse or dependent children.

CONTINUATION FOR DISABLED EMPLOYEES

If you would not otherwise qualify for coverage at the beginning of a Benefits Year because you failed to earn enough Credit Hours due to your total disability or your temporary partial disability, you may qualify for continuation under the provisions below.

Notwithstanding anything to the contrary, this section "CONTINUATION FOR DISABLED EMPLOYEES" shall not apply if you satisfy the requirements to be classified as a Retired Employee as defined under the Plan.

Total disability will be considered to exist when you are totally disabled so as to be unable to perform every duty of any occupation for salary or wages and are under the regular care of a Doctor.

Temporary partial disability will be considered to exist when you are under the regular care of a Doctor and such Doctor allows you to return to active work on light duty.

Credit Hours During Disability

If you qualified as a Class 1 Employee during the preceding Eligibility Year, you may receive, for each day of such total disability or temporary partial disability, Credit Hours prorated on the basis of the preceding Eligibility Year's hours but only to the extent necessary to qualify you as a Class 1 Employee.

If you qualified as a Class 2 Employee during the preceding Eligibility Year, you may receive for each day of such total disability or temporary partial disability, Credit Hours prorated on the basis of the preceding Eligibility Year's hours but only to the extent necessary to qualify you as a Class 2 Employee. If these additional Credit Hours granted during your total disability or temporary partial disability will not qualify you as a Class 2 Employee, this provision will then apply only to the extent necessary to qualify you as a Class 1 Employee.

If you qualified as a Class 3 Employee during the preceding Eligibility Year, you may receive for each day of such total disability or temporary partial disability, Credit Hours prorated on the basis of the preceding Eligibility Year's hours but only to the extent necessary to qualify you as a Class 3 Employee. If these additional Credit Hours granted

during your total disability or temporary partial disability will not qualify you as a Class 3 Employee, this provision will then apply only to the extent necessary to qualify you as a Class 2 Employee or a Class 1 Employee, whichever the case may be.

In order to qualify for this provision, you must have qualified as a Class 1 Employee or earned enough Credit Hours to qualify as a Class 2 or Class 3 Employee during the Eligibility Year immediately preceding the Eligibility Year in which you failed to work the required number of consecutive months or earn the number of Credit Hours to remain a Class 1, Class 2 or Class 3 Employee because of total disability or temporary partial disability.

The preceding provisions shall also apply to Class 11 and 12 Employees, but only to provide such Employees with continued Class 11 or 12 coverage, whichever the case may be.

Extending Coverage For Additional Year(s)

An Employee may have hours added to extend coverage for a second consecutive year provided that such Employee qualified for coverage for each of the five (5) consecutive Eligibility Years immediately preceding the Eligibility Year in which the Employee failed to qualify for coverage because of a total disability or temporary partial disability.

An Employee may have hours added to extend coverage for a third consecutive year provided that such Employee qualified for coverage for each of the ten (10) consecutive Eligibility Years immediately preceding the Eligibility Year in which the Employee failed to qualify for coverage because of a total disability or temporary partial disability.

The continuance coverage provided under this provision will be that of a Class 1 Employee except that Class 2 or Class 3 will apply if the Employee qualified as a Class 2 or Class 3 Employee during each year of the immediately preceding five or ten consecutive Eligibility Years, whichever the case may be, used to determine continuance of coverage. Hours can never be added to increase to a higher classification than the previous year.

Summary

Disability Crediting – Continuation for Disabled Employees

- 3 consecutive year maximum disability crediting added as follows:

Consecutive Prior Years of Coverage	Can Add
1 year	1 year
At least 5 years	2 years
At least 10 years	3 years

CONTINUATION FOR DISABLED DEPENDENTS

All Dependent coverages provided under the Plan will be continued for an eligible Dependent unmarried child who becomes temporarily disabled, as certified by a Doctor, if the Dependent is qualified to enroll as a full-time student in a college, university, or educational institution which furthers the education of the Dependent and prepares him/her for earning a livelihood, as certified by a registrar of such institution. Any coverage continued for such Dependent will end on the sooner of:

(1) one year from the date the disability began; or
(2) the date the Employee's coverage ends.

CONTINUATION FOR DEPENDENTS OF DECEASED EMPLOYEES

Your Dependents may be covered for Class 1 benefits for one additional Benefits Year if you earned at least 1,000 Credit Hours during each of the five Eligibility Years immediately preceding your death or for two additional Benefit Years if you earned at least 1,000 Credit Hours during each of the ten Eligibility Years immediately preceding your death.

The benefits for your eligible Dependents may be continued in effect if:

(i) you are covered as a Retired Employee; or
(ii) your surviving spouse satisfies the requirements for a Surviving Spouse's Pension under the Maritime Association – I.L.A. Pension Plan as a result of your having a minimum of twenty years of Credited Service (as defined under the Pension Plan) and you would have satisfied the eligibility requirements for an age pension under the Pension Plan at the time of your death;
(iii) you have a minimum of twenty years Credited Service at the time of your death.

Notwithstanding anything to the contrary, the insurance for your eligible Dependents may only be continued in effect until the date of remarriage of the surviving spouse. Such remarried surviving spouse shall cease to be considered a Qualified Widow under this Plan.

NOTE: THE BOARD HAS DISCRETIONARY AUTHORITY TO INTERPRET THE TERMS OF THE PLAN AND TO DETERMINE ELIGIBILITY FOR AN ENTITLEMENT TO PLAN BENEFITS.

SECTION II – SCHEDULE OF BENEFITS

LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE, & ACCIDENT AND SICKNESS DISABILITY

Class 1 Employees

Life Insurance	
Payable to beneficiary in the event of death from any cause	$16,000
Accidental Death & Dismemberment Insurance[1]	
For Covered Loss of: Life; 2 hands; 2 feet; sight of 2 eyes; 1 hand and 1 foot; 1 hand and sight of 1 eye; or 1 foot and sight of 1 eye	$11,000
For Covered Loss of: 1 hand; 1 foot; or sight of 1 eye	$5,500

[1] If the person suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

Eligible Dependents of Class 1 Employees

Life Insurance	
Payable to you in the event of death of a Dependent from any cause	
Spouse	$15,000
Child, less than 6 months	$1,000
Child, at least 6 months but younger than 19 years[2] and never married	$5,000

[2] Covered children ages 19 to 20 who have never been married if attending high school on a full-time basis; or 19 but less than 23 years who have never been married and who are attending a college or university on a full-time basis.

Class 2 Employees

Life Insurance	
Payable to beneficiary in the event of death from any cause	$23,000
Accidental Death & Dismemberment Insurance[1]	
For Covered Loss of: Life; 2 hands; 2 feet; sight of 2 eyes; 1 hand and 1 foot; 1 hand and sight of 1 eye; or 1 foot and sight of 1 eye	$23,000
For Covered Loss of: 1 hand; 1 foot; or sight of 1 eye	$11,500
Accident and Sickness Disability Benefits	
Benefits begin the 1st day in case of disability due to bodily injuries and the 8th[2] day in case of disability due to sickness, pregnancy or disease,	$40.00 per day

(but not prior to the first day of treatment by a physician), and are payable up to 26 weeks during any one period of disability.	

[1] If the person suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.
[2] NOTE: If you are confined in a Hospital due to sickness or have out-patient treatment prior to the eighth day of disability, benefits will be payable beginning with the first day of hospital treatment.

Eligible Dependents of Class 2 Employees

Life Insurance	
Payable to you in the event of death of a Dependent from any cause	
Spouse	$15,000
Child, less than 6 months	$1,000
Child, at least 6 months but younger than 19 years[1] and never married	$5,000

[1] Covered children ages 19 to 20 who have never been married if attending high school on a full-time basis; or 19 but less than 23 years who have never been married and who are attending a college or university on a full-time basis.

Class 3 Employees

Life Insurance	
Payable to beneficiary in the event of death from any cause	$38,000
Accidental Death & Dismemberment Insurance[1]	
For Covered Loss of: Life; 2 hands; 2 feet; sight of 2 eyes; 1 hand and 1 foot; 1 hand and sight of 1 eye; or 1 foot and sight of 1 eye	$38,000
For Covered Loss of: 1 hand; 1 foot; or sight of 1 eye	$19,000
Accident and Sickness Disability Benefits	
Benefits begin the 1st day in case of disability due to bodily injuries and the 8th [2] day in case of disability due to sickness, pregnancy or disease, (but not prior to the first day of treatment by a physician), and are payable up to 26 weeks during any one period of disability.	$45.00 per day

[1] If the person suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.
[2] NOTE: If you are confined in a Hospital due to sickness or have out-patient treatment prior to the eighth day of disability, benefits will be payable beginning with the first day of Hospital treatment.

Eligible Dependents of Class 3 Employees

Life Insurance	
Payable to you in the event of death of a Dependent from any cause	
Spouse	$15,000
Child, less than 6 months	$1,000
Child, at least 6 months but younger than 19 years and never married[1]	$5,000

[1] Also covered children ages 19 to 20 who have never been married if attending high school on a full-time basis; or 19 but less than 23 years who have never been married and who are attending a college or university on a full-time basis.

Retired Employees

Life Insurance	
Payable to beneficiary in the event of death from any cause	
Retired Employee with 20 or more years of service who retired on or after October 1, 1974	$16,000
Any other Retired Employee	$15,000

Eligible Dependents of Class 1, 2 and 3 Retired Employees

Life Insurance	
Payable to you in the event of death of a Dependent from any cause	
Qualified Spouse of Retired Employee	$15,000
Qualified Widow of Retired Employee who has not remarried	$15,000
Child, less than 6 months	$1,000
Child, at least 6 months but younger than 19 years[1] and never married	$5,000

[1] Also covered children ages 19 to 20 who have never been married if attending high school on a full-time basis; or 19 but less than 23 years who have never been married and who are attending a college or university on a full-time basis.

Class 5 Retired Employees

Life Insurance	
Payable to beneficiary in the event of death from any cause	$15,000

Eligible Dependents of Class 5 Retired Employees

Life Insurance	
Payable to you in the event of death of a Dependent from any cause	
Qualified Spouse of Class 5 Retired Employee	$15,000
Qualified Widow of Class 5 Retired Employee who has not remarried	$15,000
Child, less than 6 months	$1,000
Child, at least 6 months but younger than 19 years[1] and never married	$5,000

[1] Also covered children ages 19 to 20 who have never been married if attending high school on a full-time basis; or 19 but less than 23 years who have never been married and who are attending a college or university on a full-time basis.

Class 11 and Class 12 Employees

Life Insurance	
Payable to beneficiary in the event of death from any cause	$15,000
Accidental Death & Dismemberment Insurance[1]	
For Covered Loss of: Life; 2 hands; 2 feet; sight of 2 eyes; 1 hand and 1 foot; 1 hand and sight of 1 eye; or 1 foot and sight of 1 eye	$10,000
For Covered Loss of: 1 hand; 1 foot; or sight of 1 eye	$5,000

[1] If the person suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

Eligible Dependents of Class 11 and Class 12 Employees

Life Insurance	
Payable to you in the event of death of a Dependent from any cause	
Spouse	$15,000
Child, less than 6 months	$1,000
Child, at least 6 months but younger than 19 years[2] and never married	$5,000

[2] Also covered children ages 19 to 20 who have never been married if attending high school on a full-time basis; or 19 but less than 23 years who have never been married and who are attending a college or university on a full-time basis.

MEDICARE PART B PREMIUM REIMBURSEMENT:

The Board of Trustees may, from time to time and in their sole discretion, reimburse the Medicare Part B premiums paid by Retired Employees and surviving spouses receiving a disability or age pension under the Maritime Association – I.L.A. Pension Plan, other than by reason of a Qualified Domestic Relations Order. The amount of and eligibility conditions for such reimbursement shall be determined by the Board of Trustees and set forth in a resolution adopted by the Board of Trustees. Any person eligible for a reimbursement of Medicare Part B Premiums that may be approved and adopted by the Board of Trustees will be notified by mail of the requirements and conditions for such reimbursement.

Please note that there is a contractual statute of limitation with respect to benefits that is different than otherwise provided for by common law. Such contractual statute of limitation is discussed further on page 26.

LIFE INSURANCE

The Life Insurance benefit will be paid if you die while insured under this benefit.

Benefit Determination: The amount of benefit to be paid will be the amount as shown in the Schedule of Benefits section which is in force for you on the date of death, subject to all the terms and conditions of this Plan.

Benefit Payment: The benefit will be paid to the named Beneficiary, upon receipt of due proof of death, as provided for in Section IV Claim Payment and Procedures.

Assignment of Benefits: You may make an assignment of all the incidents of ownership of your benefit, but only if the Funds are given actual notice of the assignment. Any such assignment will not take effect with the Funds prior to the date a copy of the assignment is received at the Fund Office. The Funds assume no responsibility for the validity or sufficiency of any such assignment. Collateral assignments, by whatever name, are not permitted.

For Dependents: The benefit payable for the death of a dependent will be paid to you in one lump sum if a dependent dies while insured under this Plan. The amount of the benefit to be paid will be the amount shown in the Schedule of Benefits section, subject to all the terms and conditions of this Plan. The benefit will be paid upon receipt of due proof of death, as provided in Section IV Claim Payment and Procedures.

Conversion Privilege; If your life insurance benefit under this Plan, or any portion thereof, terminates, you may be 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 through ULLICO (the "Conversion Policy"). If you are interested in more information on the possibility of converting your coverage to a Conversion Policy upon termination of coverage, please contact the Fund Office.

Accelerated Benefit: Under certain circumstances, you may be entitled to an Accelerated Benefit with respect to the life insurance benefit to which you are eligible for. An Accelerated Benefit is the amount of life insurance that will be paid in accordance with the terms and conditions of the Accelerated Benefit provisions of this Plan prior to your death if the conditions of such provisions of the Plan are met. See Appendix A for a full description of the provisions of this benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The following terms are defined for purposes of Accidental Death and Dismemberment Insurance only:

Illness – A disorder or disease of the body or mind. Illness shall include: (a) pregnancy; (b) childbirth; and (c) related medical conditions. The Illness must first manifest itself while this benefit is in force.

Injury – Bodily harm that: (a) the Person sustains while this benefit is in force; and (b) is not the result of an Illness.

Upon receipt of due proof of loss, the Accidental Death and Dismemberment benefit will be paid if:

1. you, while insured under this benefit, suffer an accidental Injury; and
2. as the direct result of the accident, and independent of all other causes, you suffer a Covered Loss within 90 days after the accident.

The amount of benefit payable for a Covered Loss will be as shown in the Schedule of Benefits section.

If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

Limitations and Exclusions:

Benefits are not paid for losses caused directly or indirectly by:

1. bodily or mental Illness or disease of any kind;
2. ptomaines or bacterial infections, except those which occur with and through a cut or wound at the time of the accident;
3. intentional self-inflicted injury;
4. medical or surgical treatment (except surgical treatment required by the accident and performed within 90 days after the accident);
5. war or any act of war, declared or undeclared;
6. suicide or attempted suicide while sane or insane; or
7. medical or surgical treatment of an Illness or disease.

ACCIDENT AND SICKNESS DISABILITY BENEFITS

The benefits shown in the applicable Schedule of Benefits in Section II will be paid to you if, while covered, you become disabled within 90 days after the date you last worked under regular coverage for an Employer. You must be a Class 2 or Class 3 Employee and accumulate at least 1,400 Credit Hours in order to be eligible for Accident and Sickness Disability Benefits. You will be considered disabled if you are not able to perform every duty of your regular job because of an injury or illness. The weekly benefit will be reduced by the amount of any compensation you receive from any Employer for the same seven day period for which a weekly benefit is paid.

Periods of Disability

Payment of benefits for any one period of disability is limited to the number of weeks shown in the Schedule of Benefits.

Periods of disability due to the same or related causes count as one period unless separated by 2 weeks' full time Active Work of no less than 54 total hours. If a later period is due to a different cause and starts after you go back to Active Work for a full day of no less than 4 total hours, it will be a new period of disability.

Doctor

The disability must be certified by a legally qualified Doctor.

You must also be under the regular care of a legally qualified Doctor during the period benefits are payable. Regular treatment shall be defined as patient/Doctor contact on a basis of not less than once a month.

Limitations and Exclusions:

Benefits will not be paid for any disability:
1. due to any injury arising from any employment; or
2. due to illness covered by Worker's Compensation.

Benefits are not payable if you are receiving Worker's Compensation or *pension benefits* in accordance with the terms and conditions of the Maritime Association – I.L.A. Pension Plans. Specifically, you cannot receive age or disability pension benefits under the Maritime Association – I.L.A. Pension Plan and Accident and Sickness Benefits concurrently.

Special provisions may apply if you are receiving Accident and Sickness Disability Benefits at the time you become eligible for pension benefits (Accident and Sickness Benefits will be reduced by the Pension Plan benefits if this provision applies). Contact the Administrator if such a situation exists.

INDIVIDUAL CERTIFICATES OF INSURANCE

ULLICO will issue the individual Certificates of Insurance to the Funds, to be delivered to a covered person upon request by such covered person. The Certificate will state:

1. a summary of the benefits for which the individual is insured, including conversion rights if any; and
2. to whom the benefits are payable; and
3. any other condition of this Plan that affect insured individuals.

If there is a difference between the provisions of this Plan and a Certificate of Insurance, the provisions of this Plan will govern.

Please note that there is a contractual statute of limitation with respect to benefits that is different than otherwise provided for by common law. Such contractual statute of limitation is discussed further on page 22.

BENEFICIARY (Life Insurance and Accidental Death & Dismemberment)

The amount shown in the applicable Schedule of Benefits in Section II will be paid to your beneficiary if you die from any cause while insured, as discussed below. The payment will be made as soon as practicable upon receipt of proof of death and completion of all requested forms.

You may name any one or more person(s) as your beneficiary to receive the benefits under this Plan upon your death. You must file the name or names at the Fund Office of the Plan on a form provided by the Fund Office. You may change your beneficiary at any time, without the consent of the previously named beneficiary, by giving notice in writing. The effective date of the change is the date the request is received in the Fund Office. However, the Plan is not liable for any amount paid before the request is received.

Upon receipt of satisfactory proof of claim, payment of the death benefit due under this Plan will be made to the named beneficiary or beneficiaries as follows:

1. If you have named more than one beneficiary, each surviving beneficiary will share equally, unless otherwise indicated by you when naming the beneficiaries.

2. If there is no named beneficiary, or if no named beneficiary is surviving at the time of death, payment will be made to the first surviving class in the following order of preference:

   a. the surviving spouse;
   b. the insured's children, in equal shares;
   c. the insured's parents, in equal shares;
   d. the insured's brothers and sisters, in equal shares; or
   e. the executors or administrators of the insured's estate.

   In order to determine which class of individuals is entitled to the death benefit, the Administrator may rely on an Affidavit of Heirship or other court heirship proceedings. If payment is made based on such affidavit, the Funds will be discharged of its liability for the amount so paid, unless written notice of claim by another individual listed above is received before payment is made.

3. If the beneficiary is a minor or someone not able to give a valid release for payment, the Administrator will pay the benefit to his or her legal guardian. If there is no legal guardian, the Administrator may pay the individual or institution who has, in its opinion, custody and principal support of such beneficiary. The Funds will be fully discharged of its liability for any amount of benefit so paid in good faith.

SECTION IV – CLAIM PAYMENT AND PROCEDURES

PAYMENT OF CLAIMS

- Life Insurance – Any benefits paid for life insurance will be paid to the designated beneficiary. See Beneficiary section for more information..

- Accidental Death and Dismemberment Insurance – For a Covered Loss, benefits under Accidental Death and Dismemberment Insurance will be paid to you and in case of loss of life, benefits will be paid to your beneficiary. See Beneficiary section for more information.

- Accident and Sickness Benefits – All benefits payable on your behalf will be paid to you, if living, otherwise to the recognized beneficiary or if none, to your estate.

The Trustees will be discharged of their obligations to the extent any such payment made in good faith.

Notice of Claim:

Written Notice of Claim must be given within 90 days after loss, or as soon as possible. The notice must be given to the Welfare Fund Office, or an authorized agent, with self-identifying information. Upon receipt of such notice of claim, you will be provided a form for filing a claim.

Proof of Loss:

In addition to an initial notice of claim, written proof must be given to the Welfare Fund Office along with any claim forms as provided by the Welfare Fund Office within ninety days after the date of loss. However, a claim will still be considered if it was not possible to furnish proof within this time and the proof was furnished as soon as possible.

The proof of loss must include all information necessary for the Claims Processor to determine the (1) nature of the loss and (2) date of the loss. See "How to File a Claim" for more information on what to file to satisfy proof of loss requirements.

Time of Payment:

All benefits provided by the Plan will be paid upon receipt of proof of loss that conforms to all requirements as set forth herein and within 60 days after receipt of proof of loss.

Physical Examination and Autopsy:

The Trustees will have the right to require an examination of any person and to order that an autopsy be performed where not forbidden by law. This will be at the expense of the Welfare Plan.

SECTION IV – CLAIM PAYMENT AND PROCEDURES

How to File a Claim:

When filing your claim, you must submit proof. The Welfare Fund Office will have the right and opportunity to request and examine any document (including, but not limited to, death certificates, marriage licenses, certified birth certificates, divorce decrees, college letters, decrees of conservatorship of child(ren), medical proof of incapacitation, proof of job related disability, etc.) necessary to determine eligibility for benefits. The Administrator may require other documents to establish the validity of the claim.

Upon receipt of notice of a claim, the Welfare Fund Office will send you a letter setting forth the documents needed for the particular claim and will enclose any corresponding forms to be completed by you. The general forms and documents necessary to establish satisfactory proof of claim for the various benefits under this plan are as follows:

Life Insurance Claim and Accidental Death Claim:

- Proof of Death Statement Form;
- Certified Copy of Death Certificate;
- Assignment of Benefits Verification Form;
- Itemized list of funeral expenses and notarized assignment from the provider of funeral service, if applicable.

Dismemberment Claim:

- Statement of Dismemberment Claim Form to be completed by the Claimant;
- Statement of Dismemberment Claim Form to be completed by the last employer of the Claimant.

Accident and Sickness Claim:

- Accident and Sickness Benefit Application Form
  - Part I – completed by the Local Business Agent
  - Part II – completed by the Employee
  - Part III – completed by the Attending Physician

Send all forms to: Maritime Association – I.L.A. Welfare Fund
11550 Fuqua Street, Suite 425
Houston, TX 77034

Denial and Review of Claims

Claims for benefits under the Plan are to be submitted to the Welfare Fund Office as provided above. Payment of claims under the Plan will be made through the Welfare Fund Office.

If you receive an Adverse Benefit Determination with respect to your claim, you will receive a written notification. Any notice that denies a benefit claim in whole or in part shall, in a manner calculated to be understood by the Claimant that provides the following:

- 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; and
- With respect to a claim for a disability benefit:
    - include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the Claimant to the Plan of Health Care Professionals treating the Claimant and vocational professionals who evaluated the Claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's benefit determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and (iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;
    - if the Adverse Benefit Determination is based on an exclusion or limit, either explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or state that such explanation will be provided free of charge to the Claimant upon request
    - provide either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan that was 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; and
    - state that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant information.

An Adverse Benefit Determination is any denial, reduction or termination of or failure to provide or make payment (in whole or in part) for a Plan benefit, including any denial, reduction, termination or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan. With respect to a claim for disability benefits, an Adverse Benefit Determination also means any rescission of disability coverage under the Plan with respect to a Claimant (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For purposes of the preceding sentence, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

You will be notified of the decision regarding your claim within a reasonable time, but no later than 30 days after the claim is submitted. However, if special circumstances require an extension of time to review your claim and you are notified in advance of the need for such an extension, you will be notified of the decision regarding your claim within 45 days after the claim is submitted.

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Claim Processor responsible for making the initial determination within 180 days after you receive notice of denial. Appeals should be made to the address indicated on the notice you receive from the Claim Processor.

You have the right to review documents relevant to your claim. A document, record or other information will be considered if:

- It was relied upon by the Claim Processor in making the decision;
- It was submitted, considered or generated (regardless of whether it was relied upon);
- It demonstrates compliance with the Claim Processor's administrative process for ensuring compliance with plan documents and consistent decision-making;
- It constitutes a statement of Plan policy or guidance regarding the denied treatment or service; or
- If new information or documents is relied upon for review on appeal, you will receive a copy of that information or document and will be provided sufficient time to respond to such additional information.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Claim Processor on your claim, without regard to whether their advice was relied upon in deciding your claim.

Your claim will be reviewed by a different person from 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 information that may be submitted by you or other new documents and information the reviewer considers in the review. The review of an appeal is limited to the evidence and rationales relied upon in the initial denial of the claim and the additional documents and information submitted by you, unless you are furnished with proper notice and sufficient opportunity to respond to the other additional documents and information.

You will be sent a notice of decision on review within 30 days of receipt of the appeal.

Review of Adverse Benefit Determination

A Claimant has the right to have an Adverse Benefit Determination reviewed in accordance with the following claims review procedure:

As to claims other than as described in the paragraph below:

- The Claimant must submit a written request for such review to the Benefits Administrator, on behalf of Board of Trustees, not later than 60 days following receipt by the Claimant of the Adverse Benefit Determination notification;

- The Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits to the Benefits Administrator, on behalf of Board of Trustees;
- The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all relevant information; and
- The Claimant shall have the right to have all comments, documents, records, and other information submitted by the Claimant relating to the claim for benefits considered on review without regard to whether such comments, documents, records or information was considered in the initial benefit determination.

As to claims for disability benefits:

- To exercise the right to request a review of an Adverse Benefit Determination, a Claimant must initially submit a written request for such review to the Benefits Administrator, on behalf of Board of Trustees, not later than 180 days following receipt by the Claimant of the Adverse Benefit Determination notification;
- If such initial review results in an Adverse Benefit Determination, a Claimant may request a subsequent review of the Adverse Benefit Determination by an Independent Fiduciary by submitting a written request for such review to the Benefits Administrator, on behalf of the Independent Fiduciary, not later than 180 days following receipt by the Claimant of such Adverse Benefit Determination;
- The Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits to the Benefits Administrator, on behalf of Board of Trustees or, as applicable, the Independent Fiduciary;
- The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all relevant information;
- The Claimant shall have the right to have all comments, documents, records, and other information submitted by the Claimant relating to the claim for benefits considered on review without regard to whether such comments, documents, records or information was considered in the initial benefit determination;
- The review of the Adverse Benefit Determination shall not give deference to the original decision;
- The Claimant shall have the right to have identified to him the medical or vocational experts whose advice was obtained in connection with the Adverse Benefit Determination (without regard to whether the advice was relied upon in making such determination);
- If the Independent Fiduciary conducting the review considers, relies upon, or generates (or directs the consideration of, reliance upon, or generation of) any new or additional evidence that was not considered, relied upon, or generated in connection with the initial benefit determination, then the Independent Fiduciary conducting the review shall (before such Independent Fiduciary can issue an Adverse Benefit Determination on review of the claim) provide the Claimant with such new or additional evidence free of charge (which evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notification of Adverse Benefit Determination on review is required to be

provided below to give the Claimant a reasonable opportunity to respond prior to that date); and

- Before the Independent Fiduciary conducting the review can issue an Adverse Benefit Determination on review of the claim based on a new or additional rationale, such Independent Fiduciary shall provide the Claimant with such new or additional rationale free of charge as soon as possible and sufficiently in advance of the date on which the notification of Adverse Benefit Determination on review is required to be provided below to give the Claimant a reasonable opportunity to respond prior to that date.

If the initial benefit determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Independent Fiduciary conducting the review shall consult with a Health Care Professional with appropriate training and experience in the applicable field of medicine who was not consulted, and is not the subordinate of someone who was consulted, during the initial benefit determination;

Notification of Benefit Determinations on Review

The decision on any review of your claim will be given to you in writing. The notice of 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 information and 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;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive a copy of the same; and
- In the case of an Accident and Sickness disability claim, you will receive an explanation of the views of medical or vocational experts engaged by the Plan to consider the views presented by your medical or vocational experts or the Social Security System. You will also receive an explanation of any scientific or clinical judgment utilized in the process.

As to claims for disability benefits, the Notice of an Adverse Benefit Determination upon review will also:

- Describe any applicable contractual limitations period that applies to the Claimant's right to bring an action under section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim;
- Provide either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan that was 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;

- If the Adverse Benefit Determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or state that such explanation will be provided free of charge to the Claimant upon request;
- Include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the Claimant to the Plan of Health Care Professionals treating the Claimant and vocational professionals who evaluated the Claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's benefit determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and (iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration; and
- Include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

As to the review of an Adverse Benefit Determination, the Benefits Administrator, on behalf of the Board of Trustees, shall notify a Claimant of the Board of Trustees' determination on review not later than the date of the meeting of the Board of Trustees which immediately follows the request for review or, if such request for review is filed within 30 days of such meeting, not later than the date of the second meeting of the Board of Trustees which immediately follows such request for review (which period may be extended until the third meeting of the Board of Trustees following receipt of such request for review, provided that the Benefits Administrator both determines that such an extension and the date by which the Board of Trustees expects to render the determination on review). As to final review of such claims, the Benefits Administrator, on behalf of the Independent Fiduciary, shall notify a Claimant of the Independent Fiduciaries' determination on review not later than 45 days following receipt of such request for review (which period may be extended for an additional 45 days provided that the Benefits Administrator both determines that such an extension is necessary due to special circumstances requiring an extension and the date by which the Independent Fiduciary expects to render the determination on review). The period of time within which a benefit determination on review will be made begins at the time an appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event an extension of time is necessary due to the Claimant's failure to submit necessary information, the period for making the Adverse Benefit Determination will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

In the case of an Accident and Sickness disability claim, your notices will be in a written or electronic form that is culturally and linguistically appropriate. You will be provided with a telephone hotline with oral language services to answer questions and provide filing assistance in

your non-English language, your notices will be translated in your non-English language (upon request) and your notices will contain a statement in your non-English language clearly indicating how to access these language services. These non-English language requirements will apply to you if 10% or more of the population in your county is literate in that language. Electronic notification will comply with ERISA regulatory standards.

All parties in the claims submission and review process will be independent and impartial.

Limitation on when a Lawsuit May Begin

You may not file a lawsuit to obtain benefits under the Plan until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame 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 permits you to pursue your remedies under Section 502(a) of ERISA without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than two (2) years after the end of the year in which services were provided.

PARTICIPANTS MUST EXHAUST ADMINISTRATIVE REMEDIES DISCUSSED HEREIN PRIOR TO FILING A LAWSUIT.

Construction.

The claims procedures described in this document are intended to comply with the provisions of 29 C.F.R. §2560.503-1. All provisions of these claims procedures shall be interpreted, construed, and limited in accordance with such intent. In addition, all claims and appeals for disability benefits shall be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, with respect to claims and appeals for disability benefits, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Fund Office, all documents governing the Plan, including the Plan, insurance contracts (if any), vendor contracts, and a copy of the latest annual report (Form 5500 series) filed by the Plan Administrator 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 Administrator, copies of documents governing the operation of the Plan, including the Plan, insurance contracts (if any), vendor contracts, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each participant with a copy of this summary annual report.

You are entitled to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage.

Prudent Action 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 Plan. The people who operate the 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 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

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 Administrator to provide the materials and pay you up to $110.00 a day until you receive the material. This does not apply if the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations 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 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 Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance obtaining documents from the Plan 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.

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan, covering any active Employee or current or future retiree, in whole or in part at any time. Any such, change or termination in benefits (i) will be based solely on the decision of the Plan Sponsor and (ii) may apply to all active Employees, current retirees or future retirees, as either separate groups or as one group. This is subject to the applicable provisions of the Plan.

The Plan is maintained pursuant to applicable provisions of the current collective bargaining agreement, any extensions with respect thereto, along with any memorandum of understanding, that may be entered into between the West Gulf Maritime Association and their respective regular and associated members and the South Atlantic & Gulf Coast District of the International Longshoremen's Association located from Brownsville, Texas to Lake Charles, Louisiana.

FAMILY MEDICAL LEAVE ACT OF 1993

If you have been an Employee of an Employer on a regular basis for at least 12 months and you have at least 1,250 Credit Hours with such Employer during the previous 12 month period and the Employer is a covered employer under the Family and Medical Leave Act of 1993 (FMLA), you may be entitled to a total of 12 work-weeks of leave during any 12-month period for one or more of the following reasons:

(a) Because of the birth of a child to you and in order to care for such child.
(b) Because of the placement of a child with you for adoption or foster care.
(c) In order for you to care for your spouse, child, or parent if your spouse, child, or parent has a serious health condition.
(d) Because of a serious health condition of yours which makes you unable to perform the functions of your employment.

If you believe that you are eligible for FMLA leave, you should notify your regular employer of your intention to go on a FMLA leave and provide to the employer the medical certification and other information required under FMLA. The determination of your eligibility under FMLA leave is the responsibility of your regular employer. The Welfare Fund is not responsible for administering the FMLA for Employers, determining your eligibility for leave, or providing for employment and benefit protection under FMLA except to the extent expressly stated below.

Once it is determined by your regular employer that you are entitled to FMLA leave, your employer has the obligation of notifying the Administrator of the Plan that you are eligible and when your leave begins and ends. If you are eligible for benefit coverage under this Plan in the Benefit Year (January 1 through December 31) in which your FMLA leave commences, your coverage will be maintained during that Benefit Year even though your employer is not obligated and does not make any further contributions to the Maritime Association – I.L.A. Welfare Fund on your behalf during the period of your FMLA leave.

If the period of your FMLA leave extends into the Plan Year and you have earned sufficient Credit Hours in the Plan Year in which your leave commences to make you eligible for benefit coverage in the next Benefit Year, your coverage will be maintained during that portion of the next Benefit Year you are on FMLA leave, even though your Employer is not obligated and does not make any further contributions to the Welfare Fund on your behalf during the period of your FMLA leave.

If the period of your FMLA leave extends into the next Plan Year and you have not earned sufficient Credit Hours in the Eligibility Year in which your leave commences to make you eligible for benefit coverage in the next Benefit Year and you are not qualified for a continuation of benefits on account of disability, your coverage will be maintained during that portion of the next Benefit Year you are on FMLA leave, but your Employer is obligated to make contributions to the Welfare Fund on your behalf in an amount that would be due had you extended your coverage into the next Benefit Year under COBRA to maintain your benefit coverage during the period of your FMLA leave extends into the next Benefit Year. At the conclusion of your FMLA leave, you would not have benefit coverage under the Plan for the remainder of the Benefit Year.

If you are not eligible for benefit coverage in the Eligibility Year in which your FMLA leave commences, you do not become entitled to benefit coverage for that Benefit Year by taking FMLA leave. Also, you do not earn any Credit Hours to establish eligibility under the Plan during the time that you are on FMLA leave, except to the extent you qualify for continuation of benefits on account of disability, as provided in this Plan. Finally, the provision does not affect any other provision of the Plan regarding the continuation of eligibility coverage under the Plan.

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

You may continue your coverage and coverage for your Dependents during military leave of absence in accordance with the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If you continue such coverage during such leave:

a) any required contributions must be paid to the Funds;
b) any change in benefits that occurs during the period of continuation will apply on the effective date of the change;
c) [any Actively at Work or Hospital confinement requirement will be waived;] and
d) [the continuation during a military leave will run concurrently with a continuation during any other leave of absence.]

Coverage may be continued until the earlier of:

a) 24 months; or
b) the day after you fail to return to work as outlined by the USERRA.

If you enter active duty military service and have re-employment rights as provided in the USERRA, as amended, coverage under this Plan will continue for your dependent spouse and children while your re-employment rights continue under that law. If your re-employment rights end under that law (for example, because you re-enlist or extend your enlistment), coverage will end for your Dependents on that date.

When your active duty military service ends, if your re-employment rights are guaranteed under USERRA and if you return to employment in the industry for any Employer within the time required under USERRA, your coverage will be reinstated on the date of your return under the benefit plan in which you were covered when you entered active duty military service. If the benefit plans were amended while you were in active duty military service, you would be reinstated in the amended plan. Be certain to notify the Funds Office when you return to work in order that your coverage may be promptly restored.

Notwithstanding any provision of the Plan to the contrary, benefits and service credit with respect to qualified military service will be provided in accordance with sections 414(u) and 401(a)(37) of the Code. With respect to contributions required to be paid for any benefits and service credit for such qualified military service under the USERRA or the Code, such contributions shall be allocated pro rata among those Employers that the Employee worked for in the twelve months immediately preceding deployment of qualified military service based on the hours worked for such Employers during that time; provided that if any of such Employer no longer exists or functions, the contributions otherwise attributable to that Employer shall be funded out of Plan contributions or other assets of the Plan.

SECTION VI – ADMINISTRATIVE INFORMATION

Benefit Year	January 1 through December 31
EIN and Plan No.	EIN: 74-1721447 Plan Number: 501
Plan Sponsor	Trustees of the Maritime Association – I.L.A. Welfare Plan 11550 Fuqua, Suite 425, Houston, TX 77034
Plan Administrator	Trustees of the Maritime Association – I.L.A. Welfare Plan Telephone Number – 281-484-4343 The Plan is administered pursuant to the provisions of the Plan documents.
Funding Medium	Plan assets are held in a trust fund by the Trustees. The Plan is funded solely through employer contributions, except for required Employee contributions as noted where applicable throughout this Plan document.
Trustees	Mark Bridges Bill Buckley Eloy Cortez David Eckles Chelsea Egmon Jeffery Hakala Jerry Kneisler Norman Lamb Andrew Laws Ricardo Liscano Charles Montgomery Dave Morgan Mike Shaffner Johnny Mamou Larry Sopchak Randy Stiefel Nathan Wesely
Agent for Service of Legal Process	The Plan Sponsor, the Plan Administrator or the Trustees. Process may be served at the address specified above.
Other Employers	A complete list of employers that have adopted the Plan can be obtained upon written request to the Plan Administrator and is available for inspection at the Plan office.

APPENDIX A

Accelerated Benefits

DEFINITIONS:

Accelerated Benefit(s): The amount of life insurance that will be paid in accordance with the terms and conditions of this section prior to your death if the conditions of this section below are met.

Totally Disabled and Total Disability: Your complete inability, due to injury or illness, to engage in any business, occupation or employment, for which you are qualified by reason of education, training or experience, for pay, profit or compensation.

Terminal Illness or Terminally Ill: A determination is made that you, while insured under this Plan, has a life expectancy of six months or less as a result of a medical condition caused by injury or illness.

ELIGIBILITY:

You will be eligible for this Accelerated Benefit so long as (1) you are eligible as a Class 1, 2 or 3; (2) you are an active employee; (3) you have been insured under this Plan for a minimum of two years; and (4) you are not Totally Disabled

BENEFIT AMOUNT:

The Accelerated Benefit amount will be chosen by you, except that the benefit shall not be: (1) less than $5,000; or (2) more than 50% of the life insurance amount.

PAYMENT OF THE ACCELERATED BENEFIT:

Payment of the Accelerated Benefit shall be made in one lump sum to you, or to the entity or party so designated in writing by you. Only one Accelerated Benefit shall be payable to you.

EFFECT ON LIFE INSURANCE AMOUNT:

Once the Accelerated Benefit has been paid, the life insurance amount on you shall be reduced by the amount of the Accelerated Benefit payment. The remaining life insurance amount will remain in effect, subject to any reduction or termination and all other conditions and terms of the Plan. The amount of life insurance available for conversion shall be reduced by the amount of the Accelerated Benefit payment.

I. CONDITIONS FOR WHICH BENEFITS ARE PAYABLE

Condition(s) means any of the medical conditions and circumstances for which benefits are payable under this Plan.

Benefits shall be payable under this section of the Plan for the following Conditions:

(1) The Terminal Illness which results in a life expectancy of not more than 6 months;

(2) A medical condition which requires extraordinary medical intervention, such as, but not limited to, major organ transplant or conditions for artificial life support, without which death would result;

(3) A medical condition which requires continuous confinement in an eligible Institution if you have been confined a minimum of six months, and you are expected to remain in such or similar Institution for the remainder of your life.
   a. after your effective date of coverage under this section of the Plan; and
   b. while this section of the Plan is in effect as to you.

   Institution means a nursing home or skilled nursing facility, which is licensed as such by the state, and which provides skilled nursing care by registered graduated nurses, under the direction of at least one physician.

(4) A medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, but are not limited to, one or more of the following: (a) coronary artery disease which results in acute infarction or which requires surgery; (b) permanent neurological deficit which results from cerebral vascular accident; (c) end stage renal failure; or (d) Acquired Immune Deficiency Syndrome (AIDS).

II. CONDITIONS FOR PAYMENT

Payment of an Accelerated Benefit is subject to the following:

(1) The request for payment of the benefit must be made to ULLICO in writing by you or your legal representative;

(2) The diagnosis of a Condition must be made:
   a. By a licensed qualified physician, other than you or a member of your family;
   b. After your effective date of coverage; and
   c. While this Plan provision is in effect for you.

(3) The written consent of an assignee or irrevocable beneficiary, if any, must be given to the Funds.

(4) You, at your own expense, must provide proof satisfactory to the Funds of the diagnosis and effect on life expectancy; such proof shall include, but is not limited to, clinical, radiological and laboratory evidence.

If you die after a request is made for the Accelerated Benefit, but before such benefit is paid, the Accelerated Benefit is not payable. The life insurance amount under this Plan will be paid to the Beneficiary as if no request for Accelerated Benefits had been made.

MEDICAL DETERMINATION

If you and ULLICO do not agree on the diagnosis of the Condition or its effect on life expectancy, either may request, in writing, an additional medical determination. The procedure shall be as follows:

(1) You and ULLICO shall each select an independent physician.
(2) Both physicians will: (a) examine you and all your medical records; and (b) submit a written opinion.
(3) If both physicians do not agree, they will choose a third disinterested physician acceptable to both.
(4) The third physician will examine you and your medical records, and submit a written opinion as to a final determination.
(5) If the opinion of the third physician is in favor of you, ULLICO will pay the expenses of the physicians involved.
(6) If the opinion of the third physician is in favor of ULLICO, ULLICO will pay the expenses of its physicians and of the third physician, and you shall pay the expenses of your physician.

It is agreed that this will be the sole remedy for resolving any differences of medical opinion and determination for purposes of this section of the Plan.

CONVERSION

Regardless of anything to the contrary in this Plan, the Accelerated Benefit may not be converted to an individual policy. The amount of life insurance available for conversion shall be reduced by the amount of the Accelerated Benefit payment.

EXCEPTIONS TO APPLICABILITY OF ACCELERATED BENEFITS

This section of the Plan and the Accelerated Benefit provided herein shall not apply:

(1) To any life insurance with a face amount of less than $10,000;
(2) To request for payment of the benefit for any other reason other than a Condition as described in this section of the Plan;
(3) If the required premium for group life insurance under the Plan is due and unpaid;
(4) To any supplemental life benefits, accidental death and dismemberment benefits or to any other benefits provided by ULLICO to the Funds except for the group life insurance benefits provided under this Plan;
(5) When all or a portion of your life insurance benefits are to be paid as part of a divorce settlement;
(6) If your life insurance under this Plan has been in force for less than two years or if you are Totally Disabled on the effective date of this section of the Plan;
(7) If you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise;
(8) If you are required by a government agency to use this benefit to apply for, obtain or keep a government benefit or entitlement; or

(9) If the illness or injury which caused the medical condition is caused by intentional self-inflicted injury or attempt at suicide.

TERMINATION OF ACCELERATED BENEFITS

The Accelerated Benefits for you shall terminate on the earliest of:

(1) The date the Plan is terminated; or
(2) The date this section of the Plan is terminated.

The Accelerated Benefits with respect to an individual shall terminate on the earliest of:

(1) The date your life insurance under the Plan terminates;
(2) The date you retire;
(3) The date you die; or
(4) The date of payment of Accelerated Benefits made on your behalf.

TAX IMPLICATIONS

The Funds shall not be responsible for any tax or any other effects of any Accelerated Benefits payment. The receipt of an Accelerated Benefit will reduce the death benefit, and may be taxable income to you or to your beneficiary. You and the Beneficiary must consult with a personal tax advisor.