NEW ORLEANS EMPLOYERS —

INTERNATIONAL LONGSHOREMEN'S ASSOCIATION, AFL-CIO

WELFARE PLAN

AND SUMMARY PLAN DESCRIPTION

FOR NON-MEDICARE ELIGIBLE RETIREES AND DEPENDENTS

Effective October 1, 2010

To All Participants:

The New Orleans Employers-International Longshoremen's Association, AFL-CIO, Welfare Fund started providing medical benefits, which included a $25,000 per person lifetime maximum benefit, to eligible retired employees and dependents on January 1, 1980. In 2000, the Management-International Longshoremen's Association ("MILA") created a health plan, in accordance with the 1996-2001 master contract, to provide and fund medical benefits for eligible active and retired employees and dependents. It provided administration for some benefits, while others were administered on the local level.

The Board of Trustees has decided to modify this arrangement by once again providing the medical benefits for non-Medicare eligible retirees and dependents as plan sponsor, through a separate welfare plan which it has created. The name of the new welfare plan is the New Orleans Employers-International Longshoremen's Association, AFL-CIO Welfare Plan For Non-Medicare Eligible Retired Employees And Dependents ("Welfare Plan"). The intent is not to change the nature or level of benefits that were funded or provided through MILA, but for the Board of Trustees to consolidate and provide them under one welfare plan for administrative ease. All of the terms and conditions that govern these medical benefits are set forth in the Welfare Plan. Schedule A describes the Point of Service (POS) Medical Benefit, which includes a prescription drug benefit and mental health/substance abuse benefit. Schedule B describes the $25,000 Medical Benefit, which also covers prescription drugs and has a mental health/substance abuse benefit. If on September 30, 2010 you were receiving any of these benefits through the MILA arrangement, as of October 1, 2010 you will automatically start receiving them through the new Welfare Plan.

Retired employees and dependents who qualify may be covered for the POS Medical Benefit or the $25,000 Medical Benefit, but not both. You will receive the Welfare Plan booklet with only the Schedule A or B that describes the benefits for which you are covered.

If you have any questions about your benefits, please do not hesitate to contact the Fund Office.

Yours truly,

Board of Trustees

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ARTICLE I

ADOPTION OF WELFARE PLAN

The Board of Trustees for the Trust Fund, established and maintained by the Restatement of Agreement and Declaration of Trust Dated As Of May 10, 1957, Including All Amendments Thereto Up To And Including Amendment No. 15 Dated February 27, 2002, hereby establishes and adopts the New Orleans Employers-International Longshoremen's Association, AFL-CIO Welfare Plan For Non-Medicare Eligible Retirees and Dependents (the "Welfare Plan"), effective October 1, 2010, for the purpose of providing for all medical benefits that are available to eligible retired employees and their eligible dependents who are not yet eligible for Medicare. The Welfare Plan is comprised of the provisions set forth in this document and the following two Schedules which are attached hereto and made a part hereof:

(1) Schedule A which sets forth the Point of Service (POS) Medical Benefit; and

(2) Schedule B which sets forth the $25,000 Medical Benefit.

This Welfare Plan is intended to be separate from any welfare plan for active employees and their dependents, or retired employees and their dependents who are eligible for Medicare. This document is intended to serve as both the plan document and summary plan description for the Welfare Plan. In the event any benefit described in this Welfare Plan is determined to be sponsored or provided in whole or part under another welfare plan which benefits active employees, for any reason including but not limited to funding or administrative practices, that benefit (or portion thereof) will immediately be severed from this Welfare Plan, as of the effective date of such determination.

ARTICLE II

IMPORTANT INFORMATION AS REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 AS AMENDED ("ERISA")

The following information about the Welfare Plan is being provided to you in accordance with government regulations:

(a) **Plan Name and Trust Fund**

The name of the Welfare Plan is the New Orleans Employers – International Longshoremen's Association, AFL-CIO Welfare Plan For Non-Medicare Eligible Retirees and Dependents, initially adopted effective October 1, 2010.

The Welfare Plan's benefits are provided through a jointly administered trust fund, initially established effective October 1, 1956, by the local unions of the International Longshoremen's Association, AFL-CIO, in the New Orleans and Baton Rouge area, and certain Employers in the port of New Orleans and Baton Rouge area, pursuant to collective bargaining agreements (the "Fund").

(b) **Board of Trustees**

The Welfare Plan is sponsored and administered by a joint labor-management Board of Trustees for the Fund. The current names and addresses of the Trustees are listed below. You may obtain a complete list of the Employers and Employee organizations participating in the Welfare Plan by written request. You may also examine the list at the main Fund Office during regular business hours, Monday through Friday (except holidays), upon ten days' advance written request. ERISA allows the Welfare Plan to impose a reasonable charge to cover the cost of furnishing these lists. You may want to ask the amount of the charges before requesting copies.

(c) **Type of Plan**

The Welfare Plan is a group health plan that provides medical benefits, prescription drug benefits and mental health and substance abuse benefits to eligible retired employees and their eligible dependents who are not active employees or eligible for Medicare.

(d) **Plan Sponsor, Administrator and Named Fiduciary**

The Board of Trustees is the Sponsor and Administrator of the Welfare Plan. The Board established the Welfare Plan pursuant to the Collective Bargaining Agreement and is responsible for its operation. The Board consists of an equal number of Employee and Employer representatives with equal voting power, who are selected by the Unions and Employers that have entered into the Collective Bargaining Agreement. You may obtain a copy of the Collective Bargaining Agreement upon written request to the Welfare Plan at

the main Fund Office. You may also examine the Collective Bargaining Agreement at the main Fund Office during regular business hours, Monday through Friday (except holidays), upon ten days' advance written request. ERISA allows the Welfare Plan to impose a reasonable charge to cover the cost of furnishing these lists. You may want to ask the amount of the charges before requesting copies.

The Board of Trustees is also the named fiduciary charged with the responsibility for administration of the Welfare Plan in accordance with the plan documents and all applicable laws, and with the authority to amend the Welfare Plan. The names and addresses of the individual members of the Board of Trustees are listed below. You may also contact the Board of Trustees at the following address and telephone number:

Board of Trustees
NOE-ILA, AFL-CIO Welfare Plan For Non-Medicare Eligible Retirees and Dependents
147 Carondelet Street, Suite 300
New Orleans, LA 70130
(504) 525-0309

(e) **Type of Administration**

The Welfare Plan is administered by the Board of Trustees for the Fund and assisted by an Administrative Manager appointed by the Board to administer the day-to-day operations of the Welfare Plan. The individual currently serving as the Administrative Manager is Thomas R. Daniel. If you have questions about the Welfare Plan or wish to contact the Board of Trustees, the Administrative Manager can assist you. If you wish to contact the Administrative Manager, you may use the following address and telephone number:

Administrative Manager
NOE-ILA, AFL-CIO Welfare Plan For Non-Medicare Eligible Retirees and Dependents
147 Carondelet Street, Suite 300
New Orleans, LA 70130
(504) 525-0309

(f) **Names and Business Addresses of Trustees**

The names and business addresses of the current Trustees are:

Union Trustees	**Employer Trustees**
Dwayne Boudreaux 2337 Tchoupitoulas St. New Orleans, LA 70130	Sid Hotard 3413 Jordan Road South New Orleans, LA 70126

Walter Ohler
2337 Tchoupitoulas St.
New Orleans, LA 70130

Nick Jumonville
721 Richard St.
New Orleans, LA 70130

Kenneth Crier
601 Louisiana Ave.
New Orleans, LA 70115

James Parker
50 Napolean Ave.
New Orleans, LA 70115

James McCleland, Jr.
2112 N. Arnoult Rd.
Metairie, LA 70001-2861

Mark Cummings
525 Washington Blvd., Suite 1660
Jersey City, NJ 07310

Lloyd Irvin
329 Allendale Dr.
Port Allen, LA 70767

Joseph Hightower
3413 Jordan Road South
New Orleans, LA 70126

(g) **Agent for Service of Legal Process**

The Administrative Manager has been designated as agent for acceptance of service of legal process on behalf of the Welfare Plan. Legal process may be served on the Administrative Manager at the following address:

Administrative Manager
NOE-ILA, AFL-CIO Welfare Plan For Non-Medicare Eligible Retirees and Dependents
147 Carondelet Street, Suite 300
New Orleans, LA 70130
(504) 525-0309

Service of legal process may also be made upon any individual Trustee serving on the Board.

(h) **Employer Identification Number and Plan Number:**

The Internal Revenue Service has assigned the Plan Sponsor the Employer Identification Number ("EIN") 72-0570875. The Plan Sponsor has assigned Plan Number 502 to the Welfare Plan.

(i) **Plan Year**

The records of the Welfare Plan are kept on the basis of a fiscal year which begins on October 1 and ends on the following September 30. This fiscal year is also known as the "Plan Year".

(j) **Funding of Welfare Plan**

The benefits of the Welfare Plan are provided solely through assets accumulated in the Fund for the Welfare Plan and/or through a reimbursement arrangement with the Management-International Longshoremen's Association National Health Plan as agreed to under the 1996-2001 master contract. The Fund is governed by the Trust Agreement by which it was established and is maintained. The assets of the Welfare Plan may be used only to provide benefits under the Welfare Plan to eligible retired employees and their eligible dependents and to pay the administrative costs of the Welfare Plan. The assets of the Welfare Plan are held in the custody of First NBC Bank ("Bank") and invested by the Board of Trustees under an investment agreement with the Bank. The Board of Trustees has appointed, and may appoint from time to time, certain qualified investment advisors to assist with the investment of assets.

(k) **Contribution Source**

The Welfare Plan is funded by financial assistance payments made by the Carrier-ILA Container Royalty Fund No. 5, established pursuant to the USMX-ILA Master Contract Memorandum of Settlement Between United States Maritime Alliance, Ltd. and International Longshoremen's Association, AFL-CIO, effective October 1, 2009; reimbursement payments for claims and third party administrative fees made pursuant to an arrangement with the Management-International Longshoremen's Association National Health Plan as originally agreed to under the 1996-2001 USMX-ILA Master Contract; and monthly self-payments made by eligible Retirees for the Point of Service (POS) Medical Benefit, with the current required rates being $43.00 per month for single coverage and $86.00 per month for coverage of two or more persons.

Upon written request, the main Fund Office will provide you with information as to whether a particular Employer participates in the Welfare Plan. You can also request in writing, from the main Fund Office, a copy of the agreements by which the Welfare Plan is maintained. ERISA allows the Welfare Plan to impose a reasonable charge to cover the cost of furnishing these agreements. You may want to ask the amount of the charges before requesting copies.

(l) **Eligibility and Benefits**

The types of benefits provided under the Welfare Plan, the eligibility requirements and the circumstances that may result in disqualification, ineligibility, denial or loss of benefits, are described in this booklet and in Schedules A and B, which together comprise the Welfare Plan and Summary Plan Description.

(m) **Discretionary Authority of the Board of Trustees**

The Board of Trustees has the full and exclusive authority and discretion to determine all matters arising under the Welfare Plan, including but not limited to questions of eligibility, the amount of benefits payable, methods of providing and arranging for

benefits, and interpretation and construction of the Welfare Plan and Trust Agreement by which the Fund is maintained, and to exercise all other powers specified in the Welfare Plan. Any such determination, interpretation or construction adopted by the Trustees in good faith is binding on all persons. The Board may, in its sole discretion, modify, amend or terminate the Welfare Plan in any manner and at any time. No officer, agent or employee of the Union or Employer, or any other person, is authorized to speak for, or on behalf of, or to commit the Board, on any matter relating to the Welfare Plan.

(n) **Non-Assignment of Benefits**

A participant (retired employee or dependent) in the Welfare Plan may not assign medical benefits that are payable unless and except to the extent specifically permitted by the terms of the Welfare Plan and Schedule corresponding to that medical benefit. If permitted, the assignment must be done in writing on a form that is acceptable to the Welfare Plan, and it must be received by the Welfare Plan before benefits are paid. Assignments will have no legal effect with respect to medical benefits that have been paid before notice of assignment is received.

(o) **Plan Amendment and Termination**

The Board of Trustees reserves the right to amend, modify and terminate the Welfare Plan and its benefits, in whole or part, at any time.

STATEMENT OF ERISA RIGHTS

As a participant in the New Orleans Employers–International Longshoremen's Association, AFL-CIO Welfare Plan For Non-Medicare Eligible Retirees and Dependents, you have the following rights and protections under ERISA:

Right To Receive Information About Your Plan and Benefits

(1) To examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, during regular business hours, Monday through Friday (except holidays), all documents governing the plan including the plan document and all amendments, the trust agreement, any insurance contracts, collective bargaining and participation 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.

(2) To obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts, collective bargaining and participation agreements, copies of the latest annual report (Form 5500 Series), and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

(3) To receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Right To Continue Group Health Plan Coverage

(1) To continue health care coverage for a dependent spouse and child if there is a loss of coverage under the plan as a result of a qualifying event. Your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

(2) You should be provided a certificate of creditable coverage, free of charge, from the plan: (a) when you lose coverage under the plan; (b) when you become entitled to elect COBRA continuation coverage; (c) when your COBRA continuation ends; (d) if you request it before losing coverage; or (e) if you request it up to twenty-four (24) months after losing coverage. Evidence of creditable coverage may be used to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under other group health plans. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in coverage.

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

(1) 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.

(2) 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 thirty (30) days, you may file a suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to one hundred ten dollars ($110) a day until

you receive the materials, unless 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 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 medical child support order, you may file suit in a 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 the 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.

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the plan by following its claims procedure and claims review procedure as described in this booklet and in the Schedule corresponding to the benefit being claimed, before you may file a lawsuit in any court. You will then have two years following the date a final decision on a claim is reached in which to start a lawsuit. In no event may legal action be brought in court, by you or on your behalf, later than these periods.

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 in 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.

ARTICLE III

DEFINITIONS

Whenever the following terms are used in this booklet or in Schedule A or Schedule B which describes the benefits offered under the Welfare Plan in greater detail, they will have the meaning set forth in this Article, unless a different meaning is clearly and plainly implied by the context.

Section 3.1 – "Agreement and Declaration of Trust" or "Trust Agreement" means the Restatement Of Agreement And Declaration Of Trust Dated As Of May 10, 1957, Including All Amendments Thereto Up To And Including Amendment No. 15, Dated February 27, 2002, between the Midgulf Association of Stevedores, Inc. representing the Employers, and various local unions of the International Longshoremen's Association, AFL-CIO, executed to become effective February 18, 2004, as may be amended or replaced with respect to the Welfare Plan.

Section 3.2 – "Association" means the Midgulf Association of Stevedores, Inc., which is incorporated under the laws of the State of Louisiana and represents Employers for the purpose of establishing and maintaining the Welfare Plan.

Section 3.3 – "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 and corresponding regulations, as amended.

Section 3.4 – "Code" means the Internal Revenue Code of 1986, as amended.

Section 3.5 – "Collective Bargaining Agreement" or "CBA" means the written collective bargaining agreement(s) entered into by and between an Employer (or Association on behalf of the Employers it represents) and the Union, and any extensions, renewals and successor agreements thereto, providing for contributions by an Employer to the Fund.

Section 3.6 – "Covered Employment" means employment for which an Employer is obligated to contribute to the Fund.

Section 3.7 – "Dependent" means a Retired Employee's lawful spouse as a result of a ceremonial marriage for which a license is required, as evidenced by a marriage certificate. A spouse who is legally separated from a Retired Employee will not qualify as a Dependent.

A "Dependent" also includes an unmarried child of the Retired Employee who meets the following requirements:

(a) The child must be a natural child, a stepchild by legal marriage, a legally adopted child or child placed with the Retired Employee for adoption by a court of competent jurisdiction, or a child (including a foster child) for whom legal guardianship has been awarded to the Retired Employee, who meets the age, residency and support requirements described in the following subsections (b), (c) (d) and (e). The term "placed for adoption" means that the Retired Employee assumes and has a legal obligation for the total or partial support of the child in anticipation of the adoption of such child;

(b) The child must be under age 21, or under age 23 and a full-time student enrolled in an accredited college, university or other institution of higher learning, or any age if the child is permanently and totally disabled and the disability began before age 21. To qualify as permanently and totally disabled, the child must be incapable of self-sustaining employment by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months; and

(c) The child must have the same principal place of abode as the Retired Employee for over half the year; however, beginning with the calendar year in which the child turns age 19, the child need not satisfy this residency requirement as long as the child satisfies all of the other requirements for Dependent status and qualifies for tax-free health coverage as the Retired Employee's tax dependent under Code Section 152. As a condition of coverage, the Retired Employee may be required to certify that the child qualifies for tax-free health coverage as his or her tax dependent under Code Section 152 and/or provide adequate documentation in the form required by the Welfare Plan; and

(d) The child must be primarily dependent upon the Retired Employee for financial support and maintenance (or there must be a court decree establishing the Retired Employee's responsibility for financial support of such child), and be declared as a dependent by the Retired Employee on his or her federal income tax return; and

(e) The child must meet the above requirements and qualify as a Dependent of the Retired Employee on the date the Retired Employee first becomes covered under the Welfare Plan, or the child must be a natural child of the Retired Employee who meets the above requirements and is born after the date on which the Retired Employee first becomes covered under the Welfare Plan; or

(f) The child must be recognized as an Alternate Recipient under a Qualified Medical Child Support Order or National Medical Support Notice, with a right to enroll in the Welfare Plan as a Dependent of the Retired Employee.

The support and residency requirements may also be met if (1) the Retired Employee and child's other parent are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or live apart at all times during the last six (6) months of the calendar year, and provide over half of the child's support; and (2) the child is in the custody of one or both parents for more than half of the calendar year.

Satisfactory proof of a disabled child's incapacity and inability to engage in self-sustaining employment must be submitted to the Fund Office within 31 days of the Dependent child's 21st birthday and thereafter upon request by the Trustees.

Section 3.8 – "Eligible Charge" means, with respect to a benefit, a Reasonable and Customary Charge incurred by a Participant while covered by the Welfare Plan and benefit, for medical services, equipment, supplies or prescription drugs that are Medically Necessary and for which coverage is provided.

Section 3.9 – "Employee" means any individual hired by an Employer under a Collective Bargaining Agreement (past, present or future), who works within the territorial jurisdiction of the Union as established by the Collective Bargaining Agreement, as well as regular employees of the Fund or the New Orleans Employers – ILA, AFL-CIO Royalty Escrow Account, and regular employees or representatives of the Union.

Section 3.10 – "Employer" means each Employer signatory to a Collective Bargaining Agreement and any successor thereto, that is bound by the Collective Bargaining Agreement, as well as the Union with respect to its Employees, the Trustees with respect to Employees of the Fund, and the New Orleans Employers – ILA, AFL-CIO Royalty Escrow Account with respect to its Employees, to the extent such non-signatory employers satisfy the requirements and are accepted for participation by the Trustees and agree in writing to be bound by the Trust Agreement.

Section 3.11 – "ERISA" means the Employee Retirement Income Security Act of 1974 and corresponding regulations, as amended.

Section 3.12 – "Fund" or "Trust Fund" means the portion of the trust estate of the trust fund, established and maintained pursuant to the Agreement and Declaration of Trust, that is allocated to the Welfare Plan.

Section 3.13- "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and corresponding regulations, as amended.

Section 3.14 – "Hospital" means a legally constituted institution (not owned or operated by a national or state government) which satisfies all of the following requirements:

(a) Is primarily engaged in providing to inpatients, by or under the supervision of Physicians, (1) diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons; or (2) rehabilitation services for the rehabilitation of injured, disabled or sick persons;

(b) Maintains clinical records on all patients;

(c) Has bylaws in effect with respect to its staff of Physicians;

(d) Requires that every patient be under the care of a Physician;

(e) Provides 24-hour nursing services rendered or supervised by a registered professional nurse;

(f) Is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and

(g) Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

In no event will the term "Hospital" include any institution, or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility, facility for the aged, or (except for purposes of the Mental Health and Substance Abuse Benefit), hospital or facility designated only for the treatment of mental health or substance abuse disorders.

For purposes of this definition and notwithstanding any provision to the contrary, the U.S. Public Health Service Hospital in New Orleans or Baton Rouge, Louisiana, will each be deemed a Hospital despite their ownership, as well as any institution that is a publicly owned charity Hospital.

Section 3.15 – "Medically Necessary" means that the service or supply received satisfies all of the following requirements: (a) it is required to identify or treat a bodily injury or sickness which a Physician has diagnosed or reasonably suspects and is consistent with the diagnosis and treatment; (b) it is in accordance with standards of good medical practice and required for reasons other than the convenience of the individual or Physician; (c) it is performed in the least costly setting required by the individual's condition; and (d) it is not primarily custodial care. The fact that a service or supply is prescribed by a Physician does not necessarily mean that it is Medically Necessary.

Section 3.16 – "**Network**" means, with respect to a benefit offered under the Welfare Plan, the network of preferred provider organizations (comprised of Hospitals, Physicians, health care providers and/or pharmacies) as selected or approved by the Trustees, that have agreed to provide health care services, medical equipment and supplies, and/or prescription drugs, at discounted rates to Participants with respect to that benefit. The Trustees may select or approve a different Network for each benefit that is offered and may change a Network from time to time. Participants will be notified of any changes in the Network. Any Network that is in effect for a benefit offered under the Welfare Plan will be described in the Schedule for that benefit.

Section 3.17 – "Network Provider" means, with respect to a benefit offered under the Welfare Plan, a Hospital, Physician, health care provider, health care facility and/or pharmacy, that participates in the Network and has agreed to provide health care and/or prescription drugs at discounted rates to Participants who are covered for that benefit.

Section 3.18– "Out-of-Network Provider" means, with respect to a benefit offered under the Welfare Plan, a Hospital, Physician, health care provider, health care facility and/or pharmacy, that does not participate in the Network and has not agreed to provide health care and/or prescription drugs at discounted rates to Participants who are covered for that benefit. Eligible Charges incurred for medical services, equipment, supplies and/or prescription drugs provided by an Out-of-Network Provider will be subject to a lower Co-Insurance percentage payable by the Welfare Plan than the Co-Insurance percentage that would have been payable by the Welfare Plan for a Network Provider.

Section 3.19 – "Participant" means any Retired Employee and Dependent or former Dependent thereof, who is eligible and covered for a benefit of any type under the Welfare Plan. Whenever the term "Participant" is used in a particular Schedule A or B, it refers only to those Participants in the Welfare Plan who are eligible and covered for the benefit set forth in that Schedule. For example, a "Participant", as used in Schedule A, means only those Participants who qualify for and are covered by the Point of Service (POS) Medical Benefit.

Section 3.20 – "Pension Plan" means the New Orleans Employers-International Longshoremen's Association, AFL-CIO Pension Plan, initially adopted effective October 1, 1956, amended and restated from time to time, and most recently restated effective October 1, 2009.

Section 3.21 – "Physician" means a person who is legally qualified and licensed as a medical doctor (MD) and authorized to practice medicine, prescribe and administer drugs, and if applicable, perform surgery, within the scope of his or her license.

Section 3.22 – "Plan Year" means the 12-month accounting period of the Welfare Plan, which begins on October 1 and ends on the following September 30.

Section 3.23 – "Prescription Drug" means a drug that is purchasable only with a written prescription by a Physician (except for injectable insulin).

Section 3.24 – "Qualified Medical Child Support Order" or "QMCSO" means a Medical Child Support Order that is qualified within the meaning of Section 609(a) of ERISA. A National Medical Support Notice shall also be treated as a QMCSO. A QMCSO creates or recognizes the existence of an Alternate Recipient's right, or assigns to an Alternate Recipient the right, to receive benefits for which the Participant is eligible under the Welfare Plan.

The following terms have a special meaning in determining whether an order qualifies as a QMCSO:

(a) "Alternate Recipient" is any child of a participating Retired Employee who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under the Welfare Plan as his or her Dependent;

(b) "Medical Child Support Order" is a judgment, decree, or order (including approval of a domestic relations settlement agreement), issued by a court of competent jurisdiction, that provides for child support or health benefit coverage for a Participant's Dependent child. The Medical Child Support Order must provide the following information: (1) the name and last known mailing address of the Retired Employee and each Alternate Recipient covered by the order; (2) a description of the type of coverage to be provided by the Welfare Plan to the Alternate Recipient or manner in which it is to be determined; (3) the period for which coverage is to be provided; and (iv) the name of the Welfare Plan. The order cannot require the Welfare Plan to provide any type or form of benefit or option not otherwise provided under the Welfare Plan; and

(c) "National Medical Support Notice" is a notice issued by an appropriate agency of a state or local government, that is similar in form, content, and legal effect to a Qualified Medical Child Support Order, and directs the Trustees to effectuate coverage for an Alternate Recipient as the dependent child of the non-custodial parent who is (or will become) a Participant in the Welfare Plan in accordance with a domestic relations order that includes a provision for health care coverage.

If the Fund Office receives a Medical Child Support Order or National Medical Support Notice, the following action will be taken as soon as administratively possible following receipt:

(a) The affected Retired Employee and each Alternate Recipient will be notified of receipt of the order or notice and of the Welfare Plan's procedures for determining if it qualifies as a QMCSO;

(b) A determination as to the qualified status of the order or notice will be made; and

(c) The parties will be notified of such determination.

Participants may obtain a copy of the QMCSO Procedures free of charge upon request to the Fund Office. The procedures explain in greater detail the requirements for a QMCSO, the actions to be taken by the Welfare Plan when a Medical Child Support Order or National Medical Support Notice is received, and how a determination of the "qualified" status of the order or notice will be made.

Section 3.25 – "Reasonable and Customary Charge" means, with respect to a benefit offered under the Welfare Plan, the amount of a provider's charge that the Welfare Plan recognizes as payable under such benefit, for Medically Necessary services or supplies which are covered under the benefit (subject to any applicable deductibles and limitations). The amount of the Reasonable and Customary Charge will be the lowest of the following: (a) the provider's customary charge or actual charge, whichever is lower; (b) the contractually agreed upon discounted rate for a Network Provider; and (c) the amount routinely charged by providers in the locality where the charge is incurred for similar services or supplies, with consideration given for the patient's condition, any unusual circumstances or complications and requirements for additional time, skill or experience, as determined by the Welfare Plan using such uniform method or basis as it determines to be reasonable and appropriate. For purposes of this definition, the locality means an area whose size is large enough to give an accurate representation of charges for that type of service or supply.

Section 3.26 – "Retired Employee" or "Retiree" means an Employee who is separated from Covered Employment; eligible for a normal, early, vested or disability retirement pension from the Pension Plan; and eligible for coverage under the Welfare Plan.

Section 3.27 – "Trustees", "Board of Trustees", "Employee Trustee" and "Employer Trustee" means the Trustees designated in the Trust Agreement, or their successors appointed in the manner therein specified. "Board of Trustees" means, collectively, the individuals appointed

from time to time pursuant to the Trust Agreement and serving in a Trustee capacity for the Fund. An "Employee Trustee" means a Trustee designated by the Union, and an "Employer Trustee" means a Trustee designated by the Association or an Employer.

Section 3.28 – "Union" mean a Local Union of the ILA, AFL-CIO in the New Orleans and Baton Rouge, Louisiana areas that is a signatory to the Trust Agreement.

Section 3.29 – "Welfare Plan" means the New Orleans Employers-International Longshoremen's Association, AFL-CIO Welfare Plan For Non-Medicare Eligible Retirees and Dependents, initially adopted effective October 1, 2010, as set forth in this document and Schedules A and B, as amended from time to time.

ARTICLE IV

ELIGIBILITY

Section 4.1 - Eligibility for Retired Employees

Only Retired Employees who (i) on or after October 1, 2010, first satisfy the eligibility requirements described below, or (ii) previously satisfied these eligibility requirements and on September 30, 2010 were receiving (with respect to one or more benefits offered hereunder) the same level of benefits through an arrangement between the Trustees and the Management-International Longshoremen's Association (MILA) Health Care Trust Fund, and (iii) are not eligible for Medicare, and (iv) waive or have waived their right to receive COBRA Coverage (as described in Section 4.5), are eligible to participate in the Welfare Plan. In no event may an active Employee participate in the Welfare Plan. Coverage under the Welfare Plan for Retired Employees who first satisfy the eligibility requirements on or after October 1, 2010 will be effective as of their approved retirement date under the Pension Plan or, if later, January 1 of the calendar year following the December 31 termination date of the Retired Employee's active Employee level of medical coverage. Coverage under the Welfare Plan for Retired Employees who previously satisfied the eligibility requirements and were receiving the same level of benefits on September 30, 2010 through the arrangement described above will be effective October 1, 2010.

The eligibility requirements for participation in the Welfare Plan are as follows:

(a) The Retired Employee must be retired with a normal, early, vested or disability retirement pension under the Pension Plan prior to January 1, 1990; or

(b) The Employee must (1) retire with a normal, early or vested retirement pension under the Pension Plan on or after January 1, 1990; and (2) qualify for and receive medical benefits as an active Employee at retirement (or for the calendar year after the pension is approved); or (3) have 30 or more years of pension credits under the Pension Plan; or (4) be employed in the industry or receive credited hours under the Pension Plan for a total of at least 300 hours during the three Plan Years immediately preceding the Plan Year in which his or her pension application under the Pension Plan is approved, with at least one credited hour in each of the three Plan Years; and (5) for pension applications received on or after July 1, 1999, be fully (100%) vested under the Pension Plan by completing at least five years of creditable employment; or

(c) The Employee must (1) retire with a disability retirement pension under the Pension Plan on or after January 1, 1990; and (2) qualify for and receive medical benefits as an active Employee at the time of retirement (or for the calendar year following the year in which his or her pension is approved); or (3) be employed in the industry for at least 500 hours, or receive at least 500 credited hours, in the Plan Year in which his or her pension application is approved or in the immediately preceding Plan Year; or

(d) The Employee must retire under the Pension Plan as a Foreman-Employee, be employed in the industry on his or her last day of work before retirement, and meet the requirements of subsection (c) above.

Section 4.2 - Termination of Retired Employee's Coverage

A Retired Employee's coverage under the Welfare Plan shall terminate on the first of the following dates to occur:

(a) The date of the Retired Employee's death;

(b) The date the Retired Employee first becomes eligible for Medicare;

(c) If the medical coverage elected by the Retired Employee under the Welfare Plan is contributory and requires self-payment, the last day of the last period for which the required self-payment is made timely;

(d) The date on which the Retired Employee returns to work in one of the following classifications:

(1) Non-covered work in the New Orleans/Baton Rouge area which is, in whole or substantial part, the type traditionally covered by a Collective Bargaining Agreement between the Union and the Association or an Employer; or

(2) Work as a Stevedore Foreman for an Employer that is not a signatory to the Trust Agreement under which the Welfare Fund is established; and

(e) The date the Welfare Plan terminates or is amended to terminate coverage for the class of persons to which the Retired Employee belongs.

If coverage terminates by reason of an event described in (d), the termination will be immediate and permanent for the Retired Employee and his or her Dependents.

Section 4.3 - Eligibility for Dependents of Retired Employees

If a Retired Employee is covered by the Welfare Plan, his or her Dependents (if any) who are not yet eligible for Medicare, have waived their rights to COBRA Coverage if applicable, and are not themselves active Employees, will be eligible for the same coverage as the Retired Employee, effective as of the same date or, if later, the earliest date on which the Retired Employee acquires and enrolls the eligible Dependent and pays any required self-payment. In order to enroll an eligible Dependent, the Retired Employee must notify the Fund Office in writing and provide any required documentation as requested by the Welfare Plan. However, if a Dependent, other than a newborn child, is hospitalized on the date the Dependent would otherwise become covered under the Welfare Plan, the Dependent's coverage will not begin until the date of discharge from the Hospital.

Section 4.4 – Termination of Dependent Coverage

A Dependent's coverage under the Welfare Plan will terminate on the first of the following dates to occur:

(a) The date of the Dependent's death;

(b) The date the Dependent first becomes eligible for Medicare;

(c) If the Dependent's medical coverage under the Welfare Plan is contributory and requires self-payment, the last day of the last period for which the required self-payment is timely made;

(d) The date the Dependent first becomes an Employee;

(e) The date the Dependent no longer qualifies as an eligible Dependent under the Welfare Plan;

(f) If the Retired Employee has less than 25 years of creditable service under the Pension Plan and loses coverage under the Welfare Plan by reason of his or her death, the end of the 12-month period measured from the first day of the month immediately following the Retired Employee's death;

(g) If the Retired Employee has 25 or more years of creditable service under the Pension Plan and loses coverage under the Welfare Plan by reason of his or her death, the date of the Dependent's death;

(h) The date the Retired Employee's coverage under the Welfare Plan ends for reasons other than death or the Retired Employee reaching his or her lifetime maximum benefit;

(i) The date the Dependent enters the Armed Forces on full-time active duty unless and except to the extent prohibited by law; and

(j) The date the Welfare Plan terminates or is amended to terminate coverage for a class of persons to which the Dependent belongs.

Section 4.5 - COBRA Coverage Option

Dependents have the right to continue their health coverage under the Welfare Plan, on a self-payment basis, when it would otherwise end because of certain qualifying events, to the extent required by the federal law known as COBRA (referred to as "COBRA Coverage"). The obligations and rights of Dependents under COBRA, as set forth in this Section, will be

interpreted and administered in a manner that complies with the requirements under COBRA.

(a) **Eligibility and Benefits**. A Dependent who would otherwise lose health coverage under the Welfare Plan due to one of the following events ("Qualifying Events") is entitled to elect COBRA Coverage: (1) the Retired Employee's death; (2) the Retired Employee's divorce or legal separation; (3) the Retired Employee's entitlement to Medicare; or (4) a Dependent child ceasing to qualify as a Dependent under the Welfare Plan. Each Dependent who is affected by a Qualifying Event may elect COBRA Coverage on his or her own behalf.

(b) **Qualified Beneficiary**. A "Qualified Beneficiary" is any Dependent who, on the day before a Qualifying Event occurs, has health coverage under the Welfare Plan and would otherwise lose such health coverage due to the Qualifying Event. If a Qualified Beneficiary with COBRA Coverage acquires a family member for which open enrollment would be available if the Qualified Beneficiary were a Retired Employee, the Qualified Beneficiary may add such Dependent to his or her coverage for the remainder of the COBRA Coverage period.

If a Qualified Beneficiary with COBRA Coverage has a Dependent who (1) was eligible but did not enroll for COBRA Coverage when the Qualified Beneficiary enrolled because the Dependent had other health coverage under COBRA or another health plan at that time, and (2) lost such other coverage due to exhaustion of COBRA Coverage or termination of the other health coverage due to loss of eligibility (but not due to nonpayment of premium or for cause), or due to termination of employer contributions towards the other coverage, the Qualified Beneficiary may add such Dependent to COBRA Coverage for the remainder of the COBRA period. The Qualified Beneficiary must add the Dependent to COBRA Coverage, by written notice to the Fund Office, within 30 days after the Dependent loses the other COBRA or health coverage. If COBRA Coverage ends for a Qualified Beneficiary, it will also end for any family members who are enrolled but not Qualified Beneficiaries in their own right.

(c) **Length of COBRA Coverage**. Any Dependent whose health coverage under the Welfare Plan terminates due to a Qualifying Event is eligible to elect COBRA Coverage for up to 36 months from the date such coverage would otherwise terminate.

(d) **Earlier Termination of COBRA Coverage**. Notwithstanding the maximum 36-month period of COBRA Coverage described above, a Dependent's COBRA Coverage will terminate earlier upon the first, if any, of the following events to occur:

(1) The first day of the first month for which the required COBRA self-payment is not paid timely, taking into account any applicable grace period (if the failure to pay timely relates to the first self-payment due, COBRA Coverage will not take effect);

(2) The date, after COBRA Coverage is elected, on which the individual first becomes covered under another group health plan that does not have a pre-existing condition limitation or exclusion affecting the individual (or if it does, the date the individual is no longer affected by the limitation or exclusion), or first becomes entitled to Medicare; and

(3) The date the Welfare Plan terminates as permitted under COBRA.

In the event of an earlier termination of COBRA Coverage for one of the reasons set forth above, the Fund Office will send written notice of early termination to the affected individual(s) as soon as practicable after such termination determination, setting forth the reason for termination, the date of termination and the individual's rights, if any, to alternative coverage.

(e) **COBRA Self-Payment.**

(1) **Amount**: COBRA Coverage is conditioned upon timely payment of the required self-payment amount as determined by the Trustees. The self-payment amount may not exceed the actual cost of the group health coverage plus an additional amount permitted by law. The monthly COBRA rates will remain constant for a 12-month period to the extent required by law. If an individual fails to make a self-payment within the grace period, his or her COBRA Coverage eligibility will end and cannot be reinstated.

(2) **Due Dates**: The first COBRA self-payment must cover the cost of COBRA Coverage from the date it would otherwise terminate through the end of the month in which payment is made, and is due no later than 45 days after the date COBRA Coverage is elected. All subsequent self-payments are payable monthly, quarterly or semi-annually, as elected, and due on the first day of each calendar period for which coverage is intended, subject to a 30-day grace period following the due date.

(f) **Notice Requirements.**

(1) **Required Notice from Welfare Plan**: The Welfare Plan will notify Dependents of their rights under COBRA when they first become covered. The Welfare Plan will also notify Dependents of their right to elect COBRA Coverage, in the event of a loss of coverage due to the Retired Employee's death, within 30 days after the resulting loss of coverage.

(2) **Required Notice From Retirees and Dependents**: Retirees and Dependents must give written notice to the Fund Office, promptly in advance if possible but in no event later than 60 days following any of the following Qualifying Events: a Retiree's divorce or legal separation, or loss of Dependent child status. The notice must include the name of each

Qualified Beneficiary, the type of Qualifying Event and date it occurred, and (if applicable) a copy of the divorce decree or written proof of legal separation. Failure to provide timely notice, as required, may result in forfeiture of the right to elect COBRA Coverage. The Welfare Plan will notify the affected Dependents of their right to elect COBRA Coverage, within 30 days after receiving this required notice of the Qualifying Event. Notice given to a Dependent spouse will be considered notice to all affected Dependent children living with the Dependent spouse.

(3) **Financial Responsibility for Failure to Give Notice**: If a Dependent fails to give proper and timely notice of a Qualifying Event as required by the Welfare Plan and by law, the Dependent may lose the right to elect COBRA Coverage. In addition, if the Dependent's failure to notify the Welfare Plan of the Qualifying Event results in the erroneous payment of a claim for the Dependent by the Welfare Plan, the Dependent must reimburse the Welfare Plan for the claim paid in error. If a Dependent fails to make prompt reimbursement, the Welfare Plan may deduct the amount owed from other benefits payable to or for the Dependent.

(g) **Election of COBRA Coverage**.

(1) **Written Election Required**: After learning of the occurrence of a Qualifying Event, the Welfare Plan will send to the affected individuals specific information about when and how to elect COBRA Coverage, including the amount of the required self-payment. To elect COBRA Coverage, the eligible individual must sign a written election form and return it to the Fund Office (or as otherwise directed in the notice) no later than 60 days after the later of (A) the date coverage terminates by reason of the Qualifying Event, or (B) the date the individual is notified of his or her right to elect COBRA Coverage. If elected, COBRA Coverage will be effective retroactive to the date coverage terminated due to the Qualifying Event. If an eligible individual waives COBRA Coverage during the 60-day election period, he or she may later revoke the waiver and elect COBRA Coverage provided it is done within the 60-day period. If COBRA Coverage is elected after a waiver, the Welfare Plan may provide it from the date of the subsequent election or retroactive to the loss of coverage.

(h) **Terms and Conditions**.

The following terms and conditions apply to the COBRA Coverage option:

(1) COBRA Coverage is optional, and each Qualified Beneficiary may make an independent election to receive it;

(2) The cost of COBRA Coverage must be paid entirely by the Qualified Beneficiary electing coverage; and

(3) The health benefits available during a period of COBRA Coverage will be the same health benefits provided by the Welfare Plan to similarly situated Participants with respect to whom a Qualifying Event has not occurred.

ARTICLE V

MEDICAL BENEFITS

Section 5.1 – Medical Benefits Provided Under Welfare Plan

The Welfare Plan makes the following medical benefits available to Retired Employees and Dependents who satisfy the eligibility requirements for participation in the Welfare Plan, on the terms and conditions described:

(a) **Schedule A - Point-of-Service ("POS") Medical Benefit.**

The POS Medical Benefit covers medical services furnished by Network Providers and has a prescription drug benefit and mental health/substance abuse benefit, all to the extent described in Schedule A. This medical benefit is optional and provided on a contributory basis only. Any Participant who is eligible and wishes to receive the POS Medical Benefit must enroll by notifying the Fund Office in writing when he or she first becomes eligible, waiving any COBRA Coverage to which he or she is then entitled, and paying the required monthly self-payment to the Fund Office, in the amount determined by the Trustees from time to time, on or before the 1st day of each month, subject to a grace period of 30 days.

Retired Employees and their Dependents who satisfy the eligibility requirements for participation in the Welfare Plan and, on September 30, 2010, were receiving coverage through an arrangement with the Management-International Longshoremen's Association ("MILA"), for the same medical benefits and on the same contributory basis that is provided by the POS Medical Benefit, will no longer be covered through the MILA arrangement but instead will be covered for the POS Medical Benefit under this Welfare Plan, beginning October 1, 2010. For purposes of all benefit limitations under the POS Medical Benefit, these individuals will be credited with any benefits received through the MILA arrangement. For example, an individual who has received $30,000 in medical benefits under the MILA arrangement, thereby reducing his or her remaining lifetime maximum benefit to $220,000 ($250,000 - $30,000 = $220,00), will be treated as having exhausted $30,000 of his or her $250,000 maximum lifetime benefit under the POS Medical Benefit; or

(b) **Schedule B - $25,000 Medical Benefit.**

The $25,000 Medical Benefit covers medical services (not limited to use of Network Providers) and prescription drugs up to a $25,000 lifetime maximum, and a mental health/substance abuse benefit, all to the extent described in Schedule B. This medical benefit was initially provided on an optional and non-contributory (no cost) basis, to Participants who were eligible and who enrolled prior to January 1, 1997, by notifying the Fund Office in writing when they first became eligible and waiving any COBRA Coverage to which they were then entitled. Participants who were eligible for the POS Medical Benefit and $25,000 Medical Benefit prior to January 1, 1997, had to choose between the two options, as Participants could

be covered by only one of these medical benefits. The $25,000 Medical Benefit shall be provided to existing enrollees only and shall not be open to new enrollees (including new Dependents) on or after January 1, 1997.

Retired Employees and their Dependents who satisfy the eligibility requirements for participation in the Welfare Plan and, on September 30, 2010, were receiving coverage through an arrangement with the Management-International Longshoremen's Association ("MILA") for the same level of medical benefits as those provided by the $25,000 Medical Benefit, will no longer be covered through the MILA arrangement but instead will be covered for the $25,000 Medical Benefit under this Welfare Plan, beginning October 1, 2010. For purposes of all benefit limitations and deductibles under the $25,000 Medical Benefit, these individuals will be credited with any benefits received, or out-of-pocket amounts paid, through the MILA arrangement. For example, an individual who has received $10,000 in medical benefits and satisfied $200 of a $250 calendar year deductible under the MILA arrangement, thereby reducing his or her remaining lifetime maximum benefit to $15,000 and unsatisfied portion of the $250 calendar year deductible to $50, shall be treated as having exhausted $10,000 of the $25,000 maximum lifetime benefit, and having only $50 of the $250 calendar year deductible remaining, under the $25,000 Medical Benefit.

ARTICLE VI

COORDINATION OF BENEFITS WITH OTHER PLANS AND SUBROGATION/REIMBURSEMENT RIGHTS

Section 6.1 – General Rule

The coordination of benefits ("COB") provisions, as described in this Article, apply when a Participant has coverage for health care or mental health and substance abuse treatment services under more than one group health plan. The order of benefit determination rules determine which of the group health plans covering the Participant is primary and which is secondary in determining the benefits payable under such plans. If this Welfare Plan is primary, its benefits are determined before those of any other Coordinating Plan and without considering the Coordinating Plan's benefits. If this Welfare Plan is secondary, its benefits are determined after those of the Coordinating Plan that is primary and may be reduced because of the Coordinating Plan's benefits (as the primary plan) so that payments from all plans do not exceed 100% of the total Allowable Expense. In no event will the amount of benefits payable under this Welfare Plan exceed the amount that would have been paid if no other Coordinating Plan was involved.

Section 6.2 - Definitions

The following terms, when used in the COB provisions, will have the following meanings.

(a) "**Allowable Expense**" means any necessary, reasonable and customary item of health care expense or service, including deductibles and copayments, that is covered at least in part by any of the Coordinating Plans covering the person during a Claim Determination Period. When a Coordinating Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coordinating Plans is not an Allowable Expense.

(b) "**Claim Determination Period**" means the calendar year, except that it does not include any part of a year during which a person has no coverage under the Welfare Plan.

(c) "**Coordinating Plan**" means any of the following that provides benefits or services for medical or mental health and substance abuse care: (1) any group, blanket or franchise insurance or coverage for individuals in a group (whether insured or uninsured), or any type of group Hospital or group surgical prepayment plan; (2) group Blue Cross/Blue Shield plans or other service plan contracts or prepayment coverage on a group basis, including a health maintenance organization; (3) coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefit organization plan; (4) hospital indemnity benefits in excess of $300 per day or medical care components of group long-term care contracts; (5) medical benefits under group or individual automobile contracts; and (6) coverage under a government program as permitted by law.

A "Coordinating Plan" will not include individual or family insurance or coverage; hospital indemnity insurance of $300 or less per day; school accident type coverage; and benefits for nonmedical components of group long-term care policies. The term "Coordinating Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to the portion of any such policy, contract or arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and the portion which does not.

Section 6.3 – Rules for Order of Benefit Determination

When two or more Coordinating Plans provide benefits or coverage for an Allowable Expense of a Participant, the first of the following rules that applies will determine the order in which the plans will pay or provide benefits. The Coordinating Plan that is determined to be primary will pay or provide its benefits as if no other Coordinating Plan exists. In determining its benefits, a Coordinating Plan may consider the benefits paid or provided by another Coordinating Plan only when it is secondary to the other Coordinating Plan.

The order of benefit determination rules are as follows:

(a) **Coordinating Plan Without COB Rule**: If a Coordinating Plan does not have any provision governing the coordination of benefits, it will be primary and determine its benefits first;

(b) **Coordinating Plan With COB Rule**: If the Coordinating Plan has provisions governing the coordination of benefits, the first of the following rules to apply will govern the order of determining benefits:

(1) **Nondependent/Dependent**: If one of the Coordinating Plans covers the claimant other than as a dependent (for example, as an employee, member, subscriber or retiree), it will be the primary plan, and the Coordinating Plan that covers the claimant as a dependent will be the secondary plan;

(2) **Dependent Child Covered Under More Than One Plan**: If the claimant is a dependent child covered by more than one Coordinating Plan, the order of benefits will be as follows:

(A) If the parents are either married or not separated (whether or not they have ever been married) or if a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage, the primary plan will be the plan of the parent whose birthday (excluding year of birth) occurs earlier in the calendar year, or if both parents have the same birthday, the plan that covered the parent for the longer period of time will be the primary plan;

(B) If the parents are separated or divorced and there is a court decree which establishes financial responsibility for medical care expenses with respect to the dependent child, the benefits will be determined in accordance with the court decree. Otherwise, the order of benefits will be as follows: (i) the plan of the custodial parent will be the primary plan; (ii) the plan of the spouse of the custodial parent (if any) will pay next; (iii) the plan of the noncustodial parent (if any) will pay next; and (iv) the plan of the spouse of the noncustodial parent (if any) will pay last;

(3) **Longer/Shorter Length of Coverage**: If the above rules do not establish an order of benefits determination, the Coordinating Plan that has covered the person for the longer period of time will be the primary plan with the following exception: the Coordinating Plan that covers the person as a retired employee or a retired employee's dependent child will be determined after the benefits of any other plan that covers the person as an employee.

When the COB rules operate to reduce the benefits otherwise payable under more than one provision of the mental health and substance abuse benefit, each benefit will be reduced proportionately, and only the reduced amount will be charged against any applicable benefit limit of the mental health and substance abuse benefit.

When the Welfare Plan is secondary and its benefit payment for a Participant is reduced to consider the primary plan's benefits, a record of the reduction will be kept and used to increase the benefits payable under the Welfare Plan on behalf of the same Participant for any claims incurred later in the same Claim Determination Period, but only to the extent there are Allowable Expenses for the Participant that would not otherwise be fully paid by the Welfare Plan and other Coordinating Plans. As each claim for a Participant is submitted, the Welfare Plan will do the following: (1) determine its obligation to pay or provide benefits; (2) determine whether a benefit reserve has been recorded for the Participant; and (3) determine whether there are any unpaid Allowable Expenses during the same Claim Determination Period for the Participant. If there is a benefit reserve for the Participant, the Welfare Plan will use it to pay up to 100% of the total Allowable Expenses incurred by the Participant during the same Claim Determination Period. At the end of each Claim Determination Period, each Participant's benefit reserve will return to zero, and any amounts which have not been applied because of insufficient subsequent claims incurred by the Participant during the same Claim Determination Period will be forfeited.

The Welfare Plan, or its designated provider with respect to any benefit hereunder, may release to or obtain from any other organization or person any information necessary to determine the benefits payable under the Welfare Plan and other plans and to apply the COB provisions. Upon request by the Welfare Plan, each claimant will furnish information, or provide an authorization for the Welfare Plan (or its designated provider for any benefit hereunder) to obtain information to administer the COB provisions. The Welfare Plan (or its designated provider with respect to any benefit hereunder) reserves the right to pay over to another entity or person any amount it determines to be warranted in order to satisfy the intent of these COB provisions, and any amount

so paid will fully discharge the Welfare Plan (or its designated provider for any benefit hereunder), to the extent of such payment, from further liability for the claim.

If another Coordinating Plan pays a benefit to or for a Participant that should have been paid by the Welfare Plan pursuant to its COB rules, the Welfare Plan may, in its sole discretion, reimburse the other Coordinating Plan for the amount paid in error. Any amount so paid will be deemed a benefit paid under the Welfare Plan and will satisfy the liability hereunder to the extent of such payment.

Section 6.4 - Right of Subrogation and Reimbursement

The Welfare Plan will be subrogated to any claim the Participant has or may have against a responsible third party, and have a right of reimbursement from any settlement proceeds, judgment or payment obtained by the Participant from or on behalf of a responsible third party, provided:

(a) The Participant is injured, becomes ill or suffers a condition due to the act or omission of the third party; and

(b) Benefits are paid to or on behalf of the Participant under the Welfare Plan for such injury, illness, or condition.

If the Participant recovers any payment or settlement from a third party legally responsible for an injury, illness or condition for which payment under the Welfare Plan is made, the Welfare Plan will be reimbursed out of the first funds of such recovery or settlement received by or on behalf of the Participant regardless of how they are characterized. The Welfare Plan's right of recovery will be a prior lien against the proceeds recovered by the Participant, and such right will not be defeated or reduced by the application of any "make-whole doctrine" or other such doctrine purporting to defeat the Welfare Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

The Welfare Plan (or its designated provider of any benefit hereunder) may join in any lawsuit by or on behalf of a Participant to recover his or her expenses, or bring a lawsuit in the Participant's name to recover his or her expenses if the Participant does not sue. The Participant is obligated to cooperate and execute any documents requested by the Welfare Plan or its designated provider to enforce its right of subrogation and reimbursement. No Participant may incur any expense on behalf of the Welfare Plan (or its designated provider), and no court costs or attorney's fees may be deducted from a recovery by the Welfare Plan (or its designated provider), without the prior express written consent of the Welfare Plan (or its designated provider). This right of subrogation and reimbursement may not be defeated by a "common fund doctrine" or any similar doctrine. Participants are obligated to avoid doing anything that would prejudice the Welfare Plan's (or its designated provider's) subrogation and reimbursement rights, and to execute documents and furnish information and assistance as is required to enforce these rights. If a Participant refuses or fails to make the required reimbursement as set forth in this Section and required by law, the Welfare Plan (or its designated provider) may institute legal action against the Participant to recover the benefits paid or, at its discretion, may withhold the amounts owed by the Participant from amounts payable by the Welfare Plan (or its designated provider) for unrelated subsequent or previously existing claims.

ARTICLE VII

CLAIMS PROCEDURE AND CLAIMS REVIEW PROCEDURE

The federal law known as ERISA requires the Welfare Plan to establish reasonable rules for Participants to file a claim for benefits and to appeal a decision with which they disagree. The Welfare Plan's claims and claims review procedures are described in this Article. Please read them carefully, as they tell you what must be done and when it must be done if you want to receive a benefit under the Welfare Plan or, if you file a claim but it is denied in whole or part, if you wish to appeal the denial. Failure to follow these procedures can result in a forfeiture of your right to receive a benefit or to dispute a decision made on your claim.

Section 7.1 - Definitions

Whenever the following terms are used in connection with the Claims and Claims Review Procedures as capitalized terms, they will have the meaning set forth below:

(a) "**Claim Administrator**" means the Board of Trustees, or such person or entity that it may designate from time to time with respect to a benefit or benefits provided hereunder, to handle claims and/or appeals;

(b) "**Concurrent Care Claim**" means a claim for an ongoing course of treatment over a period of time or number of treatments that is being reconsidered after an initial approval is made and before the end of the course of treatment;

(c) "**Denial**" or "**Denied**" means any denial, reduction, termination of or failure to provide or make payment for, in whole or part, a claimed benefit;

(d) "**Health Care Professional**" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law;

(e) "**Pre-Service Claim**" means a claim for benefits for which coverage is conditioned, in whole or part, on approval prior to receipt of the medical services, treatment or supplies;

(f) "**Post-Service Claim**" means a claim for benefits that involves reimbursement for the cost of medical services, treatment, supplies or a prescription drug that has already been received;

(g) "**Relevant**" means that a document, record or other information, as it relates to a claim:

(1) Was relied upon in making the benefit determination;

(2) Was submitted, considered, or generated in the course of making the benefit determination without regard to whether it was relied upon;

(3) Demonstrates compliance with administrative processes and safeguards designed to accomplish consistent and accurate determinations; or

(4) Constitutes a statement of plan policy or guidance concerning a denied treatment option or benefit for the claimant's diagnosis, without regard to whether it was relied upon in making the benefit determination;

(h) "**Urgent Care Claim**" means any claim for medical care or treatment where application of the normal time periods for pre-service authorization:

(1) Could seriously jeopardize the claimant's life, health or ability to regain maximum function; or

(2) Would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Any determination by a Physician, with knowledge of the claimant's medical condition, that a claim qualifies as an Urgent Care Claim under the above definition will be binding on the Welfare Plan; otherwise, the Claim Administrator will make the determination applying the judgment of a prudent layperson with an average knowledge of health and medicine.

Section 7.2 - Filing Requirements for Claims

(a) **General Filing Requirements**: In order to receive a benefit or determination affecting a benefit (except as provided below in subsection (b)), you must send a completed claim form to the Claim Administrator at the address noted on the form, or to the Fund Office or any Field Office. Claim forms may be obtained, free of charge, upon request to the Claim Administrator or Fund Office. Urgent Care Claims should be submitted by telephone to the applicable Claim Administrator. However, if you use a Network Pharmacy to obtain a prescription drug under the prescription drug benefit for the POS Medical Benefit, you do not have to file a claim.

All claims for the prescription drug benefit under the POS Medical Benefit must be filed before the end of the second calendar year following the date the claim is incurred in order to be eligible for payment.

All other claims for benefits must be filed within 90 days after the date the expense is incurred or as soon thereafter as is reasonably possible, but in no event later than 18 months after the expense is incurred. The claim form must be fully completed by the Participant and Physician, as appropriate, and then forwarded with all medical bills attached to the Claim Administrator, Fund Office or any Field Office. Any claim that is not filed timely will not be considered for payment (i.e., no benefits shall be payable).

(b) **Special Filing Requirements For Mental Health and Substance Abuse Benefit:**

All claims for the mental health and substance abuse benefit must be filed in accordance with the following requirements:

(1) **Mental Health and Substance Abuse Treatment in the Network:** If you receive mental health and substance abuse treatment from a Network Provider, the Provider will file a claim on your behalf; however, you must pay the Network Provider any deductible or coinsurance that is due at the time services are provided; and

(2) **Mental Health and Substance Abuse Treatment Outside the Network:** The mental health and substance abuse benefit does not generally cover mental health and substance abuse treatment by Out-of-Network Providers; however, in rare situations, you may receive emergency treatment from an Out-of-Network Provider that is eligible for reimbursement or coverage. If that is the case and you think your emergency treatment qualifies, you should file a claim for benefits in accordance with the general requirements described above in subsection (a).

(c) The following are not generally treated as claims for benefits: (1) simple inquiries about the Welfare Plan or benefits that are unrelated to any specific benefit claim; (2) requests for prior approval of benefits that do not require prior approval; and (3) for the prescription drug benefit under the POS Medical Benefit, presenting a prescription to a pharmacy to be filled under the terms of the benefit unless the request is denied in whole or part.

(d) Claims should be filed before the filing deadline and as soon as reasonably possible so that timely payment may be made. Failure to file a claim before the deadline will not invalidate or reduce the claim if you can demonstrate that it was not reasonably possible to do so.

Section 7.3 - Authorized Representative

You may designate an authorized representative, such as a spouse, to act on your behalf in filing a claim or appealing a Denied claim. A form that can be used to designate a representative is available upon request from the Claim Administrator or Fund Office. Alternatively, you may notify the Claim Administrator, in writing, of your representative's name, address and telephone number. You should notify the Claim Administrator if any limitations apply to the representation and whenever you terminate the representation. The Claim Administrator may request additional information to verify that a person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without the need for a special authorization form or written notice to the Claim Administrator.

Section 7.4 - Payment

Any benefits payable under the Welfare Plan will be paid to the provider, to the Participant if living, or for Dependents, to the Retiree through whom the Dependent's coverage is maintained.

If any benefit is payable to a Participant's estate or to an individual who is a minor or otherwise not competent to give a valid release, the Welfare Plan may, in the absence of a duly appointed representative, pay all or part of the benefit to the parent, spouse or a relative by blood, or to any other person or entity that, in the Trustees' opinion, is entitled to receive payment on behalf of such person. Any payment so made by the Trustees in good faith will fully discharge the Welfare Plan, Fund and Trustees to the extent of such payment.

Section 7.5 – Claims Procedure - Initial Claims Determination

(a) **Processing and Time Period for Responding**

Each properly filed claim will be processed for a determination as to coverage and amount owed under the Welfare Plan, without regard to whether all the necessary information accompanies the filing. The claimant (referred to as "you") will be notified of a Denial within a reasonable period of time after receipt of the written notice of claim and within the following time periods:

(1) **For Urgent Care Claims**: You will be notified of the decision, whether adverse or not, as soon as possible taking into account the medical exigencies and within 72 hours after filing. If a decision cannot be made because of insufficient information to determine if or to what extent benefits are covered or payable, the Claim Administrator will notify you or your Physician, as soon as possible and within 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You or your Physician will have 48 hours to provide the specified information and will be notified of the decision as soon as possible and within 48 hours after receipt of the requested information. If the information is not provided within 48 hours, your claim will be Denied;

(2) **For Concurrent Care Claims**: Any reduction or termination (other than by amendment or termination of the Welfare Plan) of a pre-approved course of treatment before its original pre-authorized ending is a Denial, of which notice will be given sufficiently in advance to allow you to appeal and obtain a decision on review before the treatment is reduced or terminated. Any request to extend a course of treatment beyond the approved time or number of treatments that qualifies as an Urgent Care Claim, will be decided as soon as possible taking into account medical exigencies. If the claim is filed at least 24 hours before termination of treatment, notice of the determination, whether adverse or not, will be provided to you within 24 hours after filing;

(3) **For Pre-Service Claims**: You will be notified of the determination, whether adverse or not, within 15 days after filing. If necessary due to

matters beyond the Welfare Plan's control, this 15-day period may be extended one time for up to 15 days provided you are notified, within the first 15 day-period, of the circumstances requiring an extension and the date by which a decision is expected. If an extension is necessary because of your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days to respond;

(4) **For Post-Service Claims**: You will be notified of a Denial within 30 days after filing. If necessary due to matters beyond the Welfare Plan's control, this 30-day period may be extended one time for up to 15 days provided you are notified, within the first 30 days, of the circumstances requiring an extension and the date by which a decision is expected. If an extension is necessary because of your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days to respond;

(5) For any extension of time involving a Pre-Service Claim or Post-Service Claim which is due to your failure to submit information necessary to decide the claim, the time period for making the determination will be suspended (or tolled) from the date of the notice of extension to you until the earlier of (i) the date on which your response is received by the Welfare Plan, or (ii) your deadline to respond (must be at least 45 days). You and the Claim Administrator may agree to a voluntary extension of the deadline to respond.

(b) **Content of Notice of Denial on Initial Claims**

If your claim is initially Denied, the notice of Denial will include all of the following information:

(1) Specific reason(s) for the Denial and a reference to the specific Welfare Plan provisions(s) on which it is based;

(2) A description of any additional material or information necessary to perfect the claim and the reasons why it is necessary;

(3) A copy or explanation of the Claims Review Procedure and your right to seek review;

(4) A statement of your right to bring a civil action under ERISA Section 502(a) if benefits are Denied after review;

(5) If an internal rule, guideline, protocol or similar criterion is relied upon in making the determination, either the specific rule, guideline, protocol or criterion or a statement that it was relied upon and that a copy will be provided free of charge upon request; and

(6) If the determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the Welfare Plan to your medical circumstances, or a statement that it will be provided free of charge upon request.

Section 7.6 - Claims Review Procedure

(a) **Time Period for Filing Appeals**

If your claim is initially Denied, you may appeal the decision by following the Claims Review Procedure described in this Section. If you do, you will receive a full and fair review.

You must file a written request for review of the initial decision, within 180 days after receiving notice of Denial (or within a reasonable period of time for a Concurrent Care Claim), with the Claim Administrator responsible for the initial decision at the address listed on the notice. Appeals involving Urgent Care Claims may be made orally by calling such Claim Administrator at the number listed on the back of your ID card.

Currently, there is a two-level appeal procedure for appeals involving the mental health and substance abuse benefit. All other benefits have a one level appeal procedure. The decision on appeal will be determined by the Trustees, or by the person(s) or entity designated by the Trustees to decide the appeal. If a written request for appeal is not filed timely, the initial decision on the claim will be final and binding on all persons. However, you may establish eligibility for benefits at a later date, based on additional information and evidence that was not available to you during the appeal period, if the additional information and evidence is submitted to the Welfare Plan within 12 calendar months after the date of the notice of Denial.

(b) **Documentation for Appeal and Hearings**

An appeal request must state your name and address, the date of the Denial notice being appealed, and in clear and concise terms the reason(s) for disputing the Denial. You may submit written comments, documents, records and other information relating to your claim. You may also obtain, upon request and free of charge: (a) reasonable access to, and copies of, all documents, records and other information Relevant to your claim; and (b) the names of any medical or vocational experts that gave advice to the Claims Administrator on your claim, regardless of whether it was relied upon.

You may request a hearing to present your claim on appeal; however, the reviewer on appeal will decide, in its sole discretion, if a hearing is necessary. If a hearing is granted, you will be notified of the date and may be represented by an

authorized representative.

(c) **Review of the Appeal**

The review on appeal will take into account all comments, documents, records and information submitted by you and relating to the claim, without regard to whether it was submitted or considered in the initial determination.

The review on appeal will also comply with the following requirements:

(1) It will be impartial with no deference given to the initial determination;

(2) It will be conducted by one or more Trustees, or one or more individuals or an entity appointed by the Trustees to consider and decide the appeal, provided the reviewer on appeal did not make, and is not a subordinate of the person(s) who made, the initial decision;

(3) If your claim is Denied based in whole or part on a medical judgment (such as medical necessity or a determination that the treatment is experimental or investigational), the reviewer on appeal will consult with a Health Care Professional with appropriate training and experience in the field of medicine involved in the medical judgment, who was not consulted and is not a subordinate of any Health Care Professional who was consulted in connection with the initial determination; and

(4) If the appeal is for an Urgent Care Claim, you may request a review of the claim orally or in writing, and all necessary information, including the decision on review, will be transmitted between the Welfare Plan and you by telephone, facsimile or other available similarly expeditious method.

(d) **Time Period for Decisions on Appeal**

A decision on appeal will be made within a reasonable period of time after receipt of an appeal request that has been properly and timely filed, without regard to whether all of the necessary information accompanies the filing, and in accordance with the following:

(1) **For Urgent Care Claims**: You will be notified of the decision on appeal by telephone, as soon as possible taking into account the medical exigencies and within 72 hours of receipt of the appeal, followed by a written notice;

(2) **For Non-Urgent Pre-Service and Concurrent Claims**:

One-Level Appeal Procedure: If there is a one-level appeal procedure, you will be given written notice of the decision on appeal within 30 days after your appeal request is received; and

Two-Level Appeal Procedure: If there is a two-level appeal procedure, you will be given written notice of the decision on appeal within 15 days after your appeal request is received. If more time or information is needed to make a decision, the reviewer on appeal will specify the additional information that is needed and may request up to an additional 15 days. If you are dissatisfied with the outcome at the first-level appeal, you may file another appeal with the applicable reviewer within 180 days after the date of the notice of Denial of the first-level appeal. You will be sent a notice of the decision on review for the second level appeal within 15 days after receipt of your second appeal request;

(3) **For Post-Service Claims:**

One-Level Appeal Procedure: If there is a one-level appeal procedure and the reviewer on appeal is a person or entity other than the Board of Trustees, you will be sent a notice of the decision on appeal within 60 days after your appeal request is received.

If the reviewer on appeal is the Board of Trustees, the decision on appeal will be made no later than its next regularly scheduled meeting following receipt of your appeal. However, if your request for appeal is received within 30 days of the next regularly scheduled meeting, your request for appeal may be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for appeal may be necessary. You will be advised in writing in advance if an extension is needed. Once a decision on review of your claim is reached, you will be notified in writing of the decision as soon as possible and within five (5) days after it is made;

Two-Level Appeal Procedure: If there is a two-level appeal procedure, you will be sent a notice of the decision on appeal within 30 days after your appeal request is received. If you are dissatisfied with the outcome at the first-level appeal, you may file another appeal with the applicable reviewer within 180 days after the date of the notice of Denial of the first-level appeal. You will be sent a notice of the decision on review for the second level appeal within 30 days after receipt of your second appeal request.

(e) **Content of Notice of Denial on Appeal**

If you claim is Denied on appeal, you will be provided with written notice of the benefit determination on review, which shall set forth the following information in a manner calculated to be understood by you:

(1) The specific reasons for the Denial;

(2) A reference to the specific Welfare Plan provisions on which the Denial is based;

(3) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and information Relevant to your claim, and a statement of your right to bring a civil action under ERISA Section 502(a);

(4) If an internal rule, guideline or protocol was relied upon by the Welfare Plan, you will receive either a copy of it or a statement that it was relied upon and that a copy is available upon request at no charge;

(5) If the Denial is based on the absence of medical necessity or because the treatment is experimental or investigational, or another similar exclusion or limit, you will receive an explanation of the scientific or clinical basis for the determination applying the terms of the Welfare Plan to your claim, or a statement that it is available upon request at no charge; and

(6) A statement describing any voluntary alternative dispute resolution options (such as mediation) that are available, and your right to obtain information about any such procedures, to the extent required by law.

(f) **Finality of Decision on Review**

A decision on appeal of any claim made under the Welfare Plan in accordance with the Claims Review Procedure is final and binding on all persons.

Section 7.7 - Legal Action

No action at law or in equity may be brought to recover benefits under the Welfare Plan, by or on behalf of a Participant, unless there has first been filed timely written notice of claim, with timely compliance and exhaustion of all requirements under the Claims Procedure and Claims Review Procedure. No such legal action may be brought later than two years following a final decision on a claim filed under the Welfare Plan.

ARTICLE VIII

MISCELLANEOUS PROVISIONS

Section 8.1 - Medical Examination

No medical examination will be required of any eligible Retiree or Dependent to secure coverage under the Welfare Plan. However, the Welfare Plan, upon notice and at its expense, shall have the right and opportunity to require any Participant whose injury, sickness or condition is the basis of a claim, to be examined by a Physician of its choosing as often as it may reasonably require during the pendency of the claim, and the right and opportunity to have an autopsy made in case of death where it is not forbidden by law.

Section 8.2 - Right of Recovery

Whenever erroneous payments or payments that are in excess of the total amount necessary to satisfy the intent of the Coordination of Benefits provisions or total amount due under the Welfare Plan, have been made by the Welfare Plan or its designee, the Welfare Plan or its designee, as applicable, may recover such erroneous or excess payments. Recovery may be made as follows: (a) from any person, provider or entity to or for or with respect to whom such payments are made; or (b) from any insurance company or Coordinating Plan that should have made such payments under the Coordination of Benefits provisions; or (c) by offset against other benefits payable under the Welfare Plan to or for the Participant for whom the erroneous or excess payment was made.

Section 8.3 - Assignment and Third Party Payment

Benefits payable under the Welfare Plan shall not be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any Participant, or be subject to the debts or liability of any Participant, except as specifically provided by this Section. A Participant may make a written assignment of benefits under the Welfare Plan to the provider; however, the assignment shall be without prejudice to any payment made before the Welfare Plan's receipt and acceptance of assignment, and any such payment so made shall, to the extent thereof, be in complete discharge of the Welfare Plan's legal obligation for such benefits. The Welfare Plan may also, in lieu of direct payment to a Participant, pay benefits directly to the provider of services or supplies for which claim is made, and any such payment to the provider, to the extent made, will be in complete discharge of the Welfare Plan's legal obligation for such benefits.

ARTICLE IX

ADMINISTRATION OF THE WELFARE PLAN

Section 9.1 - Administrative Authority

The Welfare Plan shall be administered by the Trustees, as designated from time to time under the Trust Agreement and acting in their capacity as the Welfare Board. The Trustees may delegate, from time to time, part or all of their administrative duties to a person(s) or entity. The organization, composition, conduct of meetings, minutes, and general administrative powers and duties of the Welfare Board, to the extent applicable, shall be the same as for the Board of Trustees under the Trust Agreement.

Section 9.2 - Powers

The Trustees are the fiduciaries of the Welfare Plan, and unless and except to the extent delegated, have full and exclusive power, authority and discretion to determine all matters arising under the Welfare Plan and Fund, in their sole discretion, consistent with the Trust Agreement. For purposes of carrying out their responsibilities and duties, the Trustees have all necessary and appropriate powers, including but not limited to the following:

(a) To establish uniform and non-discriminatory procedures, rules and regulations to carry out the Welfare Plan;

(b) To interpret and construe provisions of the Welfare Plan, Trust Agreement and all related documents; to resolve any ambiguities, inconsistencies, omissions or disputed or doubtful terms; and to have fact finder authority to decide all facts relevant to issues arising under the Welfare Plan;

(c) To make determinations as to the rights of any applicant for benefits including all questions of eligibility, coverage and benefits; to resolve all conflicts arising under the Welfare Plan; and to require Participants to furnish such information and complete such forms as the Trustees may require for proper administration of the Welfare Plan and as a condition to receiving benefits;

(d) To authorize payments due under the Welfare Plan;

(e) To determine all methods of providing or arranging for benefits;

(f) To maintain or cause any third party administrator to maintain, such records of claims as may be needed for reliable actuarial analysis of experience under the Welfare Plan;

(g) To prepare and distribute, in such manner as the Trustees determine to be appropriate, Welfare Plan documents and information as permitted or required under ERISA and, if permitted and deemed appropriate, charge for the related costs thereof;

(h) To obtain and analyze reports on receipts and disbursements of the Welfare Fund, and to keep such books of account and records of all transactions of the Welfare Board as the Trustees deem desirable;

(i) To pay from the Welfare Fund all reasonable expenses in administering and operating the Welfare Plan or incurred on behalf of the Welfare Plan, and to employ such administrative, legal, actuarial, clerical and other personnel or assistance as the Trustees in their discretion find necessary or appropriate in the performance of their duties or to carry out the daily functions of the Welfare Plan;

(j) To establish such reserves within the limits permitted by law as the Trustees deem necessary for purposes of the Welfare Plan;

(k) To employ, appoint or retain such persons or entities as they deem necessary or desirable in connection with administration of the Welfare Plan, including but not limited to certified public accountants, actuaries, consultants and legal counsel, and to delegate ministerial powers or duties;

(l) To review and increase, decrease or eliminate benefits to the extent deemed prudent and advisable; and

(m) To correct any defect, supply any omission and/or reconcile any inconsistency in such manner and to such extent as they deem necessary to carry out the purposes of the Welfare Plan.

Section 9.3 - Decisions of Trustees Final

All decisions, interpretations, and constructions adopted by the Trustees in good faith shall be conclusive, final, and binding upon all persons. The Trustees are free to use their own judgment and discretion in all things pertaining to the affairs of the Welfare Plan and, to the extent not prohibited by ERISA, shall not be personally liable for any actions or omissions done in good faith and in the exercise of their best judgment. The fact that an action or omission is based upon the advice of legal or other professional counsel employed by the Trustees shall be conclusive evidence of their good faith and best judgment.

ARTICLE X

FINANCING

Section 10.1 - Funding of Welfare Plan Benefits

All financial assistance payments made by the Carrier-ILA Container Royalty Fund No. 5, established pursuant to the USMX-ILA Master Contract Memorandum of Settlement Between United States Maritime Alliance, Ltd. and International Longshoremen's Association, AFL-CIO, effective October 1, 2009, all reimbursement payments made pursuant to the arrangement with the Management-International Longshoremen's Association National Health Plan as originally agreed to under the 1996-2001 USMX-ILA Master Contract, all required self-payments made by Participants, and any other Employer contributions and payments to the Welfare Plan that may be agreed upon in the future consistent with the Collective Bargaining Agreement, and all earnings, proceeds and increments accruing thereon, constitute the Welfare Fund, and a Depositary or Depositaries will be designated by the Trustees to receive such funds. The funds received by the Depositary or Depositaries will be held, invested and disbursed by the Depositary or Depositaries in accordance with the decisions and instructions of the Trustees.

Section 10.2 - Contributions to Fund Irrevocable

With respect to any Employer contributions that may be allocated to the Welfare Fund in the future, neither the Employer or Union shall have any right, title or interest in such contributions and no part of the Fund shall revert to an Employer or the Union; however, if a contribution is made by an Employer by a mistake of fact or law, the contribution (without credit for earnings), less any benefits that have already been paid under the Welfare Plan with respect to such contribution, may (within such guidelines as shall be established by the Trustees from time to time) be returned to the Employer within six (6) months after the Trustees determine that it was made by mistake, provided that the return is limited to contributions made within the 12-month period preceding the date the erroneous contribution is brought to the attention of the Welfare Plan, and further provided that the return is not prohibited by law and does not jeopardize the tax-exempt status of the Fund under Code Section 501(c)(9). In the event benefits that have already been paid by the Welfare Plan with respect to a mistaken contribution exceed the amount of mistaken contribution, the Trustees have the right to recoup the difference from the Employer.

Except as provided in the foregoing paragraph, it shall be impossible under the terms of the Welfare Plan, or by virtue of any amendment hereto, for any part of the corpus or income of the Fund, except for such sums as may be expended in the administration of the Welfare Plan, to be used for, or diverted to, purposes other than for the exclusive benefit of the Participants and their beneficiaries. At all times the assets in the Fund, to the extent that they are sufficient, shall be allocated for purposes of paying benefits to persons then receiving them and to persons who subsequently become eligible for benefits and for administering the Welfare Plan. Payment of benefits shall continue in accordance with the provisions of the Welfare Plan until the entire Fund is disbursed.

ARTICLE XI

AMENDMENT AND TERMINATION OF THE WELFARE PLAN

Section 11.1 - Amendment and Termination

The Board of Trustees expressly reserves the right, in its sole discretion, at any time and for any reason, to amend or terminate the Welfare Plan in whole or part, provided that no such amendment or termination shall have the effect of reinvesting in an Employer any portion of the Welfare Fund. Unless and until terminated, the Welfare Plan shall remain in full force and effect.

Any changes authorized by the Trustees will take effect on the date specified by the Trustees and will apply to all affected persons regardless of status, illness, injury, condition or disability sustained prior to the effective date of change, or any medical services or expenses which may be required due to an illness or injury sustained prior to the date of change. Eligibility and benefits under the Welfare Plan are not guaranteed or vested rights and are subject to amendment or termination at any time.

Any amendment or termination of the Welfare Plan shall be consistent with all applicable provisions of the Trust Agreement. In the event of a termination of the Welfare Plan, no further benefits will be payable under the Welfare Plan except for claims and expenses incurred prior to the termination date, which will be paid in accordance with the provisions of the Welfare Plan or, to the extent not provided, as determined by the Trustees. In no event will there be any liability on the Welfare Plan, Fund, Trustees, Employers, Union, or any other person to provide payments over and beyond the amounts and assets available in the Fund for the purpose of providing benefits. Upon termination of the Welfare Plan, the Trustees shall, within the limits of the Welfare Plan's resources, adopt a plan to discharge all outstanding obligations under the Welfare Plan and to provide that all remaining assets be used in a manner that best carries out the basic purposes for which the Welfare Plan was established, or otherwise be disposed of in a manner consistent with applicable law.

ARTICLE XII

GENERAL PROVISIONS AND EXECUTION

Section 12.1 - Construction and Savings Clause

In the construction of the Welfare Plan, the masculine will include the feminine and the singular the plural in all cases where such meanings are appropriate.

The headings and sub-headings in this Welfare Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions.

If any provision of the Welfare Plan is held to be unlawful or unlawful as to any person or instance, such fact will not adversely affect the other provisions of the Welfare Plan or the application of the other provisions to any other person or instance, unless the illegality makes the functioning of the Welfare Plan impossible.

Section 12.2 - Governing Laws

This Welfare Plan, as amended, shall be governed, construed, and administered in accordance with the laws of the United States of America or as otherwise applicable, by the laws of the State of Louisiana, and all questions pertaining thereto shall be determined in accordance with those laws.

Section 12.3 - Benefits Not Guaranteed

Each Participant, beneficiary and other person seeking benefits under the Welfare Plan shall look solely to the assets of the Welfare Fund for such benefits, and benefits shall be paid only to the extent that the assets of the Welfare Fund are sufficient.

Section 12.4 - Status as Voluntary Employees' Beneficiary Association

The Welfare Fund is intended to qualify as a voluntary employees' beneficiary association ("VEBA") within the meaning of Code Section 501(c)(9), and shall be maintained, administered and interpreted in a manner that is consistent with its status as a VEBA and so that the Welfare Fund, from which Welfare Plan benefits are paid, shall maintain its tax-exempt status under Code Section 501(c)(9).

Section 12.5 – HIPAA Privacy and Security Rule

The law known as "HIPAA" resulted in federal privacy and security rules that require health plans, such as the Welfare Plan, to protect the confidentiality of protected health information for retired employees and dependents (also referred to as "PHI"). PHI is defined under HIPAA and generally includes individually identifiable health information created or received by the Welfare Plan. A complete description of your privacy rights can be found in the Welfare Plan's Privacy Notice, which is distributed upon enrollment. You may also request a copy of the Privacy Notice at any time by contacting the Fund Office.

We will not use or disclose your PHI except as is necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law, or as otherwise authorized by you. We have required our business associates, such as the Welfare Plan's consultants, that may create or receive PHI on our behalf to observe the privacy and security rules with respect to such PHI.

We will not, without your authorization, use or disclose PHI for employment-related actions and decisions or in connection with any of our other benefits or employee benefit plans. If someone other than you, even a friend or relative, contacts us and wants to discuss a claim or matter involving your PHI, your authorization will first be required unless the discussion is otherwise permitted under HIPAA. Written explanations of benefits (EOBs) for Dependents will be mailed to the participating Retired Employee through whom the Dependent has coverage, unless the Dependent provides other written instructions to the Welfare Plan.

You have certain rights under the privacy rules with respect to your PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information and to amend the information in certain circumstances. You also have the right to file a complaint with the Welfare Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Your rights are explained in greater detail in the Privacy Notice for the Welfare Plan.

Signed at New Orleans, Louisiana, on the 26th day of February 2013, effective as of October 1, 2010 unless otherwise provided.

BOARD OF TRUSTEES OF NEW ORLEANS EMPLOYERS — INTERNATIONAL LONGSHOREMEN'S ASSOCIATION, AFL-CIO WELFARE PLAN FOR NON-MEDICARE ELIGIBLE RETIREES AND DEPENDENTS

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Dwayne Boudreaux

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