NEW ORLEANS EMPLOYERS – INTERNATIONAL LONGSHOREMEN'S ASSOCIATION, AFL-CIO WELFARE PLAN

SUMMARY PLAN DESCRIPTION (SPD)

Dental, Vision, Death, Accidental Death and Dismemberment and Temporary Disability Income Benefits

Effective January 1, 2008

The New Orleans Employers – International Longshoremen's Association, AFL-CIO Welfare Plan

147 Carondelet Street, Suite 300
New Orleans, LA 70130

(504) 525-0309

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The Segal Company

TABLE OF CONTENTS

New Orleans Employers –
International Longshoremen's Association, AFL-CIO
Welfare Plan

TO ALL ELIGIBLE PARTICIPANTS:

The Board of Trustees is pleased to present this updated Summary Plan Description (SPD), which details a number of changes to your Welfare Plan. Our Plan continues to provide supplemental benefits to the MILA National Health Plan, including vision benefits, dental benefits, death and accidental death and dismemberment benefits, and temporary disability income benefits, as outlined in this booklet.

It is important that you take the time to review this booklet and understand the provisions of your Plan. It is also important that you know what source to refer to (this Plan or the MILA National Health Plan) when you are in need of health plan services.

Keep this booklet in a safe place where you or your dependents can locate it when it is necessary. Please keep the Fund Office informed of any changes in your address or changes in your dependent's eligibility status.

If you have any questions, please contact the Fund Office and the staff will be happy to assist you.

THE BOARD OF TRUSTEES

IMPORTANT

It is important that you notify your Field Office when any of the following conditions arise:

- You change your home address;
- You wish to change your Beneficiary;
- You marry (you may need to change your name or you may desire to add your spouse as an eligible dependent);
- You acquire a child through birth, adoption or placement for adoption;
- Your eligible dependent child ceases to qualify as your dependent (e.g., the child reaches age 21 or is a student who reaches age 23;
- You and your spouse divorce.

SCHEDULE OF BENEFITS
PREMIER PLAN
Effective January 1, 2008

Active Employees and Retired Employees with Active Benefits	
Death Benefit	$30,000
Spouse's Death Benefit	$5,000

Active Employees Only	
Accidental Death and Dismemberment Maximum	$30,000
Accidental death	$30,000
Loss of both hands or both feet or sight of both eyes	$30,000
Loss of one hand and one foot	$30,000
Loss of one hand or foot and sight of one eye	$30,000
Loss of one hand or one foot	$15,000
Loss of sight of one eye	$15,000
Temporary Disability Income Benefits (Non-occupational) – Weekly Benefit	$175
Maximum Period	26 weeks
Date of First Payment	8th day of total disability due to non-occupational injury, sickness or pregnancy

Retired Employees Only	
Death Benefit	$5,000
Spouse's Death Benefit	$2,000

Active Employees and Eligible Dependents	
Vision Benefits (Once every 24 months):	
In Davis Vision Network:	
Eye Exams	$10 standard copayment
Frames and spectacle lenses/coatings on the Davis Vision formulary	$25 standard copayment

SCHEDULE OF BENEFITS
PREMIER PLAN
Effective January 1, 2008

Active Employees and Eligible Dependents	
Frames and spectacle lenses/coatings not on the Davis Vision formulary, as per provider specification	$30 credit
Contact lenses (in lieu of frames and lenses) on the Davis Vision formulary	$25 standard copayment
Contact lenses (in lieu of frames and lenses) not on Davis Vision formulary, as per provider specification	$75 credit
Premier frames on the Davis Vision formulary	$25 additional copayment
Standard anti-reflective coating lenses	$35 additional copayment
Premium anti-reflective coating lenses	$48 additional copayment
Polarized lenses	$75 additional copayment
Transitions (sun-sensitive) plastic lenses	$65 additional copayment
High-index (thinner and lighter) lenses	$55 additional copayment
Intermediate vision lenses	$30 additional copayment
Contact lenses medically necessary for correction of keratoconus	$500 maximum benefit
Laser Vision Correction Services	Significant discounts through a network of experienced, credentialed surgeons
Out of Davis Vision Network:	**Plan Pays:**
Eye Exams	$30
Frames Only	$30
Single Vision Lenses	$25
Bifocal Lenses	$35
Trifocal Lenses	$45
Contact Lenses (in lieu of frames and lenses)	$75
Contact lenses medically necessary for correction of keratoconus	$225 maximum benefit

SCHEDULE OF BENEFITS
PREMIER PLAN
Effective January 1, 2008

Active Employees and Eligible Dependents	
Dental Benefits	
Type I (Preventive)	
Calendar Year Deductible	None
Oral exams, prophylaxis, fluoride treatment, space maintainers, palliative emergency treatment and emergency office visits	Plan pays 100%
Calendar Year Maximum	$1,500*
Type II (Basic)	
Calendar Year Deductible	$50 per person**
X-Rays, laboratory tests and other diagnostic examinations, simple extractions, surgical extractions, oral surgery, alveolectomy, anesthesia, therapeutic injections, restorations, denture repair, bridge repair, endodontics, and periodontics	Plan pays 80%
Calendar Year Maximum	$1,500*
Type III (Major)	
Calendar Year Deductible	$50 per person**
Inlays, onlays, crowns and prosthetics	Plan pays 50%
Calendar Year Maximum	$1,500*
Type IV (Orthodontic) (For Dependent Children Only)	
Lifetime Deductible	$50
Orthodontic appliances and orthodontic treatment	Plan pays 50%
Lifetime Maximum	$1,000

* Type I, II and III dental expenses have a combined (not separate) $1,500 Calendar Year Maximum.

** Type II and III dental expenses are combined to meet the $50 Calendar Year Deductible.

SCHEDULE OF BENEFITS
BASIC PLAN
Effective January 1, 2008

Active Employees and Retired Employees with Active Benefits	
Death Benefit	$21,000
Spouse's Death Benefit	$3,500

Active Employees Only	
Accidental Death and Dismemberment Maximum	$21,000
Accidental death	$21,000
Loss of both hands or both feet or sight of both eyes	$21,000
Loss of one hand and one foot	$21,000
Loss of one hand or foot and sight of one eye	$21,000
Loss of one hand or one foot	$10,500
Loss of sight of one eye	$10,500
Temporary Disability Income Benefits (Non-occupational) – Weekly Benefit	$122.50
Maximum Period	26 weeks
Date of First Payment	8th day of total disability due to non-occupational injury, sickness or pregnancy

Retired Employees Only	
Death Benefit	$5,000
Spouse's Death Benefit	$2,000

Active Employees and Eligible Dependents	
Vision Benefits (Once every 24 months)	
In Davis Vision Network:	
Eye Exams	$10 standard copayment
Frames and spectacle lenses/coatings on the Davis Vision formulary	$25 standard copayment

SCHEDULE OF BENEFITS
BASIC PLAN
Effective January 1, 2008

Active Employees and Eligible Dependents	
Frames and spectacle lenses/coatings not on the Davis Vision formulary, as per provider specification	$30 credit
Contact lenses (in lieu of frames and lenses) on the Davis Vision formulary	$25 standard copayment
Contact lenses (in lieu of frames and lenses) not on the Davis Vision formulary, as per provider specification	$75 credit
Premier frames on the Davis Vision formulary	$25 additional copayment
Standard anti-reflective lenses	$35 additional copayment
Premium anti-reflective lenses	$48 additional copayment
Polarized lenses	$75 additional copayment
Transitions (sun-sensitive) plastic lenses	$65 additional copayment
High-index (thinner and lighter) lenses	$55 additional copayment
Intermediate vision lenses	$30 additional copayment
Contact lenses medically necessary for correction of keratoconus	$500 maximum benefit
Laser Vision Correction Services	Significant discounts through a network of experienced, credentialed surgeons
Out of Davis Vision Network:	**Plan Pays:**
Eye Exams	$30
Frames Only	$30
Single Vision Lenses	$25
Bifocal Lenses	$35
Trifocal Lenses	$45
Contact Lenses (in lieu of frames and lenses)	$75
Contact lenses medically necessary for correction of Keratoconus	$225 maximum benefit

SCHEDULE OF BENEFITS
BASIC PLAN
Effective January 1, 2008

Active Employees and Eligible Dependents	
Dental Benefits	
Type I (Preventive)	
Calendar Year Deductible	None
Oral exams, prophylaxis, fluoride treatment, space maintainers, palliative emergency treatment and emergency office visits	Plan pays 100%
Calendar Year Maximum	$600*
Type II (Basic)	
Calendar Year Deductible	$100 per person**
X-Rays, laboratory tests and other diagnostic examinations, simple extractions, surgical extractions, oral surgery, alveolectomy, anesthesia, therapeutic injections, restorations, denture repair, bridge repair, endodontics, and periodontics	Plan pays 80%
Calendar Year Maximum	$600*
Type III (Major)	
Calendar Year Deductible	$100 per person**
Inlays, onlays, crowns and prosthetics	Plan pays 50%
Calendar Year Maximum	$600*
Type IV (Orthodontic) (For Dependent Children Only)	
Lifetime Deductible	$100
Orthodontic appliances and orthodontic treatment	Plan pays 50%
Lifetime Maximum	$600

* Type I, II and III dental expenses have a combined (not separate) $600 Calendar Year Maximum.

** Type II and III dental expenses have a combined (not separate) $100 Calendar Year Deductible.

SCHEDULE OF BENEFITS
CORE PLAN
Effective January 1, 2008

Active Employees and Retired Employees with Active Benefits	
Death Benefit	$15,000
Spouse's Death Benefit	$2,000

Active Employees Only	
Accidental Death and Dismemberment Maximum	$15,000
Accidental death	$15,000
Loss of both hands or both feet or sight of both eyes	$15,000
Loss of one hand and one foot	$15,000
Loss of one hand or foot and sight of one eye	$15,000
Loss of one hand or one foot	$7,500
Loss of sight of one eye	$7,500
Temporary Disability Income Benefits (Non-occupational) – Weekly Benefit	$87.50
Maximum Period	26 weeks
Date of First Payment	8th day of total disability due to non-occupational injury, sickness or pregnancy

Active Employees and Eligible Dependents	
Vision Benefits (Once every 24 months)	
In Davis Vision Network:	
Eye Exams	$10 standard copayment
Frames and spectacle lenses/coatings on the Davis Vision formulary	$25 standard copayment
Frames and spectacle lenses/coatings not on the Davis Vision formulary, as per provider specification	$30 credit
Contact lenses (in lieu of frames and lenses) on the Davis Vision formulary	$25 standard copayment

SCHEDULE OF BENEFITS
CORE PLAN
Effective January 1, 2008

Active Employees and Eligible Dependents	
Contact lenses (in lieu of frames and lenses) not on the Davis Vision formulary, as per provider specification	$75 credit
Premier frames on the Davis Vision formulary	$25 additional copayment
Standard anti-reflective lenses	$35 additional copayment
Premium anti-reflective lenses	$48 additional copayment
Polarized lenses	$75 additional copayment
Transitions (sun-sensitive) plastic lenses	$65 additional copayment
High-index (thinner and lighter) lenses	$55 additional copayment
Intermediate vision lenses	$30 additional copayment
Contact lenses medically necessary for correction of keratoconus	$500 maximum benefit
Laser Vision Correction Services	Significant discounts through a network of experienced, credentialed surgeons
Out of Davis Vision Network:	**Plan Pays:**
Eye Exams	$30
Frames Only	$30
Single Vision Lenses	$25
Bifocal Lenses	$35
Trifocal Lenses	$45
Contact Lenses (in lieu of frames and lenses)	$75
Contact lenses medically necessary for correction of Keratoconus	$225 maximum benefit

SCHEDULE OF BENEFITS
CORE PLAN
Effective January 1, 2008

Active Employees and Eligible Dependents	
Dental Benefits	
Type I (Preventive)	
Calendar Year Deductible	None
Oral exams, prophylaxis, fluoride treatment, space maintainers, palliative emergency treatment and emergency office visits	Plan pays 100%
Calendar Year Maximum	$400*
Type II (Basic)	
Calendar Year Deductible	$100 per person**
X-Rays, laboratory tests and other diagnostic examinations, simple extractions, surgical extractions, oral surgery, alveolectomy, anesthesia, therapeutic injections, restorations, denture repair, bridge repair, endodontics, and periodontics	Plan pays 80%
Calendar Year Maximum	$400*
Type III (Major)	
Calendar Year Deductible	$100 per person**
Inlays, onlays, crowns and prosthetics	Plan pays 50%
Calendar Year Maximum	$400*
Type IV (Orthodontic) – No benefits are Provided for Orthodontic Services	

* Type I, II and III dental expenses have a combined (not separate) $400 Calendar Year Maximum.

** Type II and III dental expenses have a combined (not separate) $100 Calendar Year Deductible.

DEFINITIONS

Beneficiary

"Beneficiary" means the party or parties named by an Employee or a Dependent spouse, as shown on the Company's records, to receive Accidental Death and Dismemberment Benefits and/or Death Benefits upon the death of the Employee or Dependent spouse. The Employee or Dependent spouse may name one or more Beneficiaries to receive such benefits.

COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 and any interpretive regulations thereunder.

Collective Bargaining Agreement

"Collective Bargaining Agreement" means the agreement(s) entered into between the Midgulf Association of Stevedores, Inc. on behalf of Employers they represent, other Employers, and the Union, providing for Employer contributions to the Plan.

Company

"Company" means the insurance company insuring the Death Benefit and the Accidental Death and Dismemberment Benefit.

Contribution Credit Hours

"Contribution Credit Hours" means hours as reported for an Employee by an Employer that become credits toward determining eligibility and participation in the Plan. Contribution Credit Hours for Employees of the Fund, the Union, the International Union and the New Orleans Employers – ILA, AFL-CIO Royalty Escrow Account will be contributed and credited at the rate of 40 hours per week.

Covered Employment

"Covered Employment" means employment for which an Employer is obligated to contribute to the Plan.

Dentist

"Dentist" means a person duly licensed to practice dentistry, or any other physician furnishing any dental services that he or she is licensed to perform. Dental prophylaxis performed by a hygienist employed by, and acting under the direct supervision of a Dentist, will be deemed to have been performed by a Dentist.

Dental Expense Charges

"Dental Expense Charges" means the Reasonable and Customary charges for dental care made by a Dentist for services rendered or supplies furnished to a Participant while covered for Dental Benefits, and that are necessary to his or her dental care and treatment.

Dependent

"Dependent" means any of the following:

(1) An Employee's lawful spouse for federal tax purposes.

(2) An Employee's unmarried children who meet the age and residency requirements described in (3) and (4), and for whom the Employee provides over half of their support. Unmarried children for the purpose of this definition include:

- An Employee's natural child.
- An Employee's stepchild by legal marriage.
- A child who has been legally adopted by the Employee or placed with the Employee for adoption by a court of competent jurisdiction. The term "placed" for adoption means the assumption and retention by an Employee of a legal obligation for total or partial support of a child in anticipation of the adoption of such child.
- An eligible foster child, which is an individual who is placed with the Employee by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.
- A child for whom legal guardianship has been awarded to the Employee by a court of competent jurisdiction, provided the child qualifies for tax-free health coverage as the Employee's tax dependent under Code Section 152. The Plan may require, as a condition of coverage, that the Employee certify to the Plan that the child qualifies for tax-free health coverage as the Employee's tax dependent under Code Section 152 and/or provide adequate documentation thereof in the form required by the Plan.

(3) An Employee's unmarried children will meet the age requirements if they satisfy any one of the following requirements: (a) they are under the age of 21; or (b) they are under the age of 23 and a full time student in an accredited college, university or other institution of higher learning; or (c) regardless of age, they are permanently and totally disabled provided such disability began before they reached 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.

(4) An Employee's unmarried children must have the same principal place of abode as the

Employee for over half the year; however, beginning with the calendar year in which an Employee's unmarried child turns age 19, the unmarried child will qualify as the Employee's Dependent without regard to this residency requirement, provided the child satisfies all of the other requirements under the Plan's definition of Dependent and qualifies for tax-free health coverage as the Employee's tax dependent under Code Section 152. The Plan may require, as a condition of coverage, that the Employee certify to the Plan that a child qualifies for tax-free health coverage as the Employee's tax dependent under Code Section 152 and/or provide adequate documentation thereof in the form required by the Plan.

(5) An Employee's child who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under the Plan as the Employee's Dependent.

The requirements that the Employee provide over half of the child's support and that the child have the same principal abode as the Employee for over half of the year will not apply if: (a) the Employee and the 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; (b) the Employee and the child's other parent provide over half of the child's support; and (c) the child is in the custody of one or both parents for more than half of the calendar year.

Employed in the Industry/Employment in the Industry

"Employed in the Industry" and "Employment in the Industry" mean being employed by one or more Employers under the Collective Bargaining Agreements, being regularly employed as an employee or representative of the Union, being regularly employed as an employee by the Trustees or the New Orleans Employers – ILA, AFL-CIO Royalty Escrow Account, or being regularly employed as an employee or representative of the International Union provided such employee or representative lives in the Geographical Area and does not have Employer Contributions made on his or her behalf by another Employer on a 40 hours per week basis.

Employee

"Employee" means anyone hired by an Employer under the Collective Bargaining Agreement who is working within the territorial jurisdiction of the Union, as well as regular employees of the Fund or the New Orleans Employers – ILA, AFL-CIO Royalty Escrow Account, regular employees or representatives of the Union, and regular employees or representatives of the International Union who live in the Geographical Area and do not have Employer Contributions made on their behalf by another Employer on a 40 hours per week basis.

Employer

"Employer" means each employer signatory to one or more Collective Bargaining Agreements, as well as the Union with respect to its Employees, the Trustees with respect to Employees of the Fund, the New Orleans Employers – ILA, AFL-CIO Royalty Escrow Account with respect to its Employees, and the International Union with respect to its Employees, to the extent such non-signatory employers satisfy the requirements for participation as established by the Trustees and agree to be bound by the trust agreement for the Fund.

Employer Contributions

"Employer Contributions" means payment to the Fund by an Employer, at the applicable contribution rate, for all hours in Covered Employment worked by its Employees. For Employees of the Fund, Royalty Escrow Account, Union and International Union, Employer Contributions are made on a 40 hours per week basis.

ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974 and any interpretive regulations thereunder.

Family and Medical Leave or FMLA Leave

"Family and Medical Leave" or "FMLA Leave" means a family or medical leave of absence under the Family and Medical Leave Act of 1993 and any interpretive regulations thereunder.

Foreman-Employee

"Foreman-Employee" means any person employed in the shipping industry and also employed as a stevedore foreman in the New Orleans area performing work for which the Board of Trustees for Foremen Benefits, New Orleans, Louisiana, accepts contributions for welfare benefits.

Fund

"Fund" means the trust estate of the New Orleans Employers – International Longshoremen's Association, AFL-CIO Welfare Fund, as established and maintained pursuant to the Agreement and Declaration of Trust.

Geographical Area

"Geographical Area" means the area contained within the geographical limits of the International Longshoremen's Association, AFL-CIO Local Unions in New Orleans and Baton Rouge, Louisiana.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and any interpretive regulations thereunder.

Illness

For purposes of the "Death Benefits" and "Accidental Death and Dismemberment Benefits" sections only, "Illness" means a disorder or disease of the body or mind. Illness shall include pregnancy, childbirth and related medical conditions.

Injury

For purposes of the "Death Benefits" and "Accidental Death and Dismemberment Benefits" sections only, "Injury" means bodily harm that you sustain while covered for Death Benefits and/or Accidental Death and Dismemberment Benefits, which is not the result of an Illness.

International Union

"International Union" means the International Longshoremen's Association, AFL-CIO.

Non-Bargaining Unit Employee

"Non-Bargaining Unit Employee" means an Employee who is participating in this Plan but is not employed under a Collective Bargaining Agreement.

Participant

"Participant" means any Employee or former Employee or any Dependent or former Dependent who is covered for benefits under the Plan.

Physician

"Physician" means a person who is legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, prescribe and administer drugs and, if applicable, perform surgery within the scope of his or her license. Solely for purposes of the Death Benefit and Accidental Death and Dismemberment Benefit, the definition of "Physician" also means a licensed or certified health care provider as required by state law, for services that are within the scope of the health care provider's license or certificate.

Plan

"Plan" means the New Orleans Employers – International Longshoremen's Association, AFL-CIO Welfare Plan Rules and Regulations and Plan Benefits.

Plan Year

"Plan Year" means the year beginning on October 1 and ending on the following September 30.

Qualified Medical Child Support Order

"Qualified Medical Child Support Order" ("QMCSO") means a Medical Child Support Order, including a National Medical Support Notice, that creates or recognizes the existence of an Alternate Recipient's right to receive benefits for which a Participant is entitled under this Plan, within the meaning of ERISA Section 609(a). In order for such an order to be a QMCSO, it must clearly specify:

- the name and last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order;

- a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

- the period of coverage to which the order pertains; and

- the name of this Plan.

"Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as a Participant's eligible Dependent.

"Medical Child Support Order" means any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- provides for child support with respect to a Participant's child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

- enforces a law relating to medical child support described in Social Security Act Section 1908 (as added by Omnibus Budget Reconciliation Act of 1993 section 13822) with respect to a group health plan.

"National Medical Support Notice" means a notice issued by an appropriate agency of a state or local government similar in form, content, and legal effect to a Qualified Medical Child Support Order that 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 this Plan pursuant to a domestic relations order that includes a provision for health care coverage.

Reasonable and Customary

"Reasonable and Customary" means the amount of a charge that does not exceed the charge routinely made by providers in the locality where the charge is incurred for similar services or supplies with consideration given for a patient's condition, unusual circumstances or complications and requirements for additional time, skill or experience.

Retired Employee

"Retired Employee" means an Employee who is separated from Covered Employment and is eligible for a Normal, Early or Disability Retirement Pension in the New Orleans Employers – ILA Pension Plan and who is eligible for retiree coverage under this Plan.

Trustees

"Trustees" means the Trustees designated in the trust agreement for the Fund or their successors.

Union or Unions

"Union" or "Unions" means Locals of the ILA, AFL-CIO in the New Orleans and Baton Rouge, Louisiana areas that are signatory to the trust agreement for the Fund.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and any interpretive regulations or rulings thereunder.

ELIGIBILITY

Eligibility for Collectively Bargained Employees

Premier Plan

You will become eligible for the Premier Plan level of benefits for a calendar year if you earn at least 1,300 Contribution Credit Hours in the Plan Year immediately preceding the calendar year. (The Plan Year runs from October 1 through September 30.)

The next Plan Year you must again earn at least 1,300 Contribution Credit Hours in order for your eligibility to continue for another calendar year. You will continue to be eligible for every calendar year beginning on January 1 following the Plan Year in which you earn at least 1,300 Contribution Credit Hours. Example:

Employment Period	Eligibility Period
You earn at least 1,300 Contribution Credit Hours during the 12 months between October 1 to September 30	The calendar year beginning January 1 (following the September 30 of the employment period) through December 31

For Death and Accidental Death and Dismemberment Benefits only, you will become eligible for benefits on October 1 immediately following the end of the Plan Year in which you earn at least 1,300 Contribution Credit Hours. Your initial eligibility will continue through December 31 of the next calendar year for a total of 15 months. Continuing eligibility for these benefits will be determined on a calendar year basis, as with the other benefits. Example:

Employment Period	Initial Eligibility Period	Continuing Eligibility Period
You earn at least 1,300 Contribution Credit Hours during the 12 months between October 1 to September 30	October 1 (following the September 30 of the employment period) through the next December 31 for a total of 15 months	The calendar year beginning January 1 (following the September 30 of the employment period) through December 31

Basic Plan

You will become eligible for the Basic Plan level of benefits for a calendar year if you earn at least 1,000 but less than 1,300 Contribution Credit Hours in the Plan Year immediately preceding the calendar year. (The Plan Year runs from October 1 through September 30.)

The next Plan Year you must again earn at least 1,000 but less than 1,300 Contribution Credit Hours in order for your eligibility to continue for another calendar year. You will continue to be

eligible for every calendar year beginning on January 1 following the Plan Year in which you earn at least 1,000 but less than 1,300 Contribution Credit Hours. Example:

Employment Period	Eligibility Period
You earn at least 1,000 but less than 1,300 Contribution Credit Hours during the 12 months between October 1 to September 30	The calendar year beginning January 1 (following the September 30 of the employment period) through December 31

For Death and Accidental Death and Dismemberment Benefits only, you will become eligible on October 1 immediately following the end of the Plan Year in which you earn at least 1,000 but less than 1,300 Contribution Credit Hours. Your initial eligibility will continue through December 31 of the next calendar year for a total of 15 months. Continuing eligibility for these benefits will be determined on a calendar year basis, as with the other benefits. Example:

Employment Period	Initial Eligibility Period	Continuing Eligibility Period
You earn at least 1,000 but less than 1,300 Contribution Credit Hours during the 12 months between October 1 to September 30	October 1 (following the September 30 of the employment period) through the next December 31 for a total of 15 months	The calendar year beginning January 1 (following the September 30 of the employment period) through December 31

Core Plan

You will become eligible for the Core Plan level of benefits for a calendar year if you earn at least 700 but less than 1,000 Contribution Credit Hours in the Plan Year immediately preceding the calendar year. (The Plan Year runs from October 1 through September 30.)

The next Plan Year you must again earn at least 700 but less than 1,000 Contribution Credit Hours in order for your eligibility to continue for another calendar year. You will continue to be eligible for every calendar year beginning on January 1 following the Plan Year in which you earn at least 700 but less than 1,000 Contribution Credit Hours. Example:

Employment Period	Eligibility Period
You earn at least 700 but less than 1,000 Contribution Credit Hours during the 12 months between October 1 to September 30	The calendar year beginning January 1 (following the September 30 of the employment period) through December 31

For Death and Accidental Death and Dismemberment Benefits only, you will become eligible on October 1 immediately following the end of the Plan Year in which you earn at least 700 but less than 1,000 Contribution Credit Hours. Your initial eligibility will continue through December 31 of the next calendar year for a total of 15 months. Continuing eligibility for these benefits will be determined on a calendar year basis, as with the other benefits. Example:

Employment Period	Initial Eligibility Period	Continuing Eligibility Period
You earn at least 700 but less than 1,000 Contribution Credit Hours during the 12 months between October 1 to September 30	October 1 (following the September 30 of the employment period) through the next December 31 for a total of 15 months	The calendar year beginning January 1 (following the September 30 of the employment period) through December 31

Eligibility for Non-Bargaining Unit Employees

You will be initially eligible for the Premier Plan level of benefits under the Plan on the first day of the month following completion of your employment probation period, provided that your Employer makes Employer Contributions on your behalf at the applicable hourly contribution rate on the basis of 40 hours per week. You will be covered under the Plan for each succeeding month that you remain in Covered Employment and your Employer makes Employer Contributions on your behalf at the applicable hourly contribution rate on the basis of 40 hours per week.

Special Eligibility Conversion

Premier Plan

If the Collective Bargaining Agreement under which you are covered requires Employer Contributions at a rate lower than the existing hourly contribution rate in the Master Contract for the Collective Bargaining Agreement, you will be required to have contributions made on your behalf for the minimum number of hours in a Plan Year, as determined using the following formula:

- Hourly rate of Master Contract x 1,300 hours = Minimum Dollar Contribution; and
- Minimum Dollar Contribution divided by your hourly contribution rate = minimum number of hours of contribution required in a Plan Year to obtain eligibility for the applicable eligibility period.

Basic Plan

If the Collective Bargaining Agreement under which you are covered requires Employer Contributions at a rate lower than the existing hourly contribution rate in the Master Contract for the Collective Bargaining Agreement, you will be required to have contributions made on your behalf within the following range of Minimum and Maximum Dollar Contributions in a Plan Year to obtain eligibility for the applicable eligibility period:

- Hourly rate of Master Contract x 1,000 hours = Minimum Dollar Contribution; and
- Hourly rate of Master Contract X 1,299 hours = Maximum Dollar Contribution.

Core Plan

If the Collective Bargaining Agreement under which you are covered requires Employer Contributions at a rate lower than the existing hourly contribution rate in the Master Contract for the Collective Bargaining Agreement, you will be required to have contributions made on your behalf within the following range of Minimum and Maximum Dollar Contributions in a Plan Year to obtain eligibility for the applicable eligibility period:

- Hourly rate of Master Contract x 700 hours = Minimum Dollar Contribution; and
- Hourly rate of Master Contract X 999 hours = Maximum Dollar Contribution.

Termination of Active Employee's Coverage

Your active Employee coverage under the Plan will terminate on the earliest of the following dates:

- If you are Employed in the Industry under a Collective Bargaining Agreement, December 31 following the end of the Plan Year in which you fail to earn the minimum number of Contribution Credit Hours or the minimum amount of Employer Contributions required for eligibility;
- For Non-Bargaining Unit Employees, the last day of the month in which your Employment in the Industry terminates;
- The date of your death;
- For all benefits, the date you enter military service in the armed forces of any country other than the United States;
- For all benefits other than Dental and Vision Benefits, the date you enter military service in the armed forces of the United States;
- For Dental and Vision Benefits, for a uniformed services leave of absence for the United States that exceeds 31 days, the first date for which a required self-payment has not been paid as required under USERRA or, if earlier, the end of the period for which coverage is required under USERRA; and
- The date the Plan is terminated or amended to exclude you from coverage.

Family and Medical Leave

An Employee who is covered under the Plan and eligible for FMLA Leave can continue coverage for Dental and Vision Benefits under the Plan during the period of FMLA Leave, provided the following conditions are satisfied:

- Your Employer must certify that the Employer is subject to the FMLA requirements and that you are eligible for FMLA Leave;

- Your Employer must timely notify the Fund of the type and duration of FMLA Leave that has been requested, and must timely furnish the necessary information to support your eligibility for FMLA Leave; and

- Your Employer must submit contributions to the Fund for the duration of the FMLA Leave to continue your coverage; you will not be required to use accumulated Contribution Credit Hours to continue your coverage during the FMLA Leave.

Continuing Eligibility During Temporary Disability

If, after you become covered under the Plan, you become disabled prior to your termination of coverage under the Plan and you are receiving benefits under Worker's Compensation or the Temporary Disability Income Benefit provisions, credit for establishing eligibility for the following calendar year will be credited on your behalf at the rate of:

- 26 Contribution Credit Hours per week, at the rate specified under the Master Contract for the Collective Bargaining Agreement, up to a maximum of 1,300 Contribution Credit Hours per Plan Year, when you become disabled while covered under the Premier Plan level of benefits;

- 20 Contribution Credit Hours per week, at the rate specified under the Master Contract for the Collective Bargaining Agreement, up to a maximum of 1,000 Contribution Credit Hours per Plan Year, when you become disabled while covered under the Basic Plan level of benefits; and

- 14 Contribution Credit Hours per week, at the rate specified under the Master Contract for the Collective Bargaining Agreement, up to a maximum of 700 Contribution Credit Hours per Plan Year, when you become disabled while covered under the Core Plan level of benefits.

Credit will be given beginning with the first week of disability and continuing for the period of disability, even if the Worker's Compensation or Temporary Disability Income benefits have been exhausted.

If, after you become covered under the Plan, you become disabled prior to your termination of coverage under the Plan and you receive a lump-sum award under Federal or State Worker's Compensation, credit for establishing eligibility for the following calendar year will be given at the same rate of Contribution Credit Hours described above. This credit will be given for the period of time determined by dividing the amount of the lump-sum award by the weekly Workers' Compensation rate, or if longer, until the disability ends.

In no event will you receive credit for more than a total of 50 weeks in a single Plan Year or credit for more than a total of 36 consecutive months beginning with the first week of disability. The maximum credit limitations apply to both lump-sum awards and periodic benefit payments, as well as to combinations of lump-sum awards and periodic benefit payments.

Continued Active Employee Coverage at Retirement

If you retire and prior to retirement you have earned sufficient hours for continuing eligibility for the following year, you will be covered (along with your Dependents) for all benefits under the Plan, except the Accidental Death and Dismemberment Benefit and the Temporary Disability Income Benefit, for the period of time for which eligibility has been earned. At the termination of such extended active Employee coverage, you and your eligible Dependents will be eligible to receive retiree Death Benefit coverage, as described on page 24, and to continue your Dental and Vision Benefits coverage under COBRA as described beginning on page 26.

Service in the Armed Forces

If you are on uniformed services leave (such as active or inactive duty training or active duty in the United States Armed Forces or National Guard) for 31 days or less, you will continue to receive Dental and Vision Benefits coverage.

If you are on uniformed services leave for more than 31 days, you will be permitted to continue Dental and Vision Benefits coverage for yourself and your Dependents at your own expense for up to 24 months.

When you are discharged (not less than honorably) from service in the uniformed services, your full eligibility will be reinstated as follows:

- On the day you make application to return to work with an Employer, provided that you make application within 90 days from the date of discharge if the period of service was more than 180 days; or

- On the day you make application to return to work with an Employer, provided that you make application 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or

- On the date you return to work, provided that you return to work at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by uniformed service, these time limits are extended up to two years.

Eligibility for Dependents of Active Employees

Your Dependents will become eligible for benefits under the Plan on the date you become eligible or, if later, on the date you acquire the Dependent, provided appropriate documentation has been submitted to the Fund Office. Your newborn child will become an eligible Dependent immediately. If a Dependent child is adopted by you or placed for adoption with you, the child will become an eligible Dependent on the date the child is adopted or placed for adoption. A child is “placed for adoption” on the date you first become legally obligated to provide full or partial support of the child you plan to adopt.

Termination of Coverage for Dependents of Active Employees

Coverage for your Dependents will terminate on the earliest of the following dates:

- The date your coverage terminates, for reasons other than your death;
- For Dependent children in the event of your death, the last day of the period for which you had qualified for coverage;
- For a Dependent spouse in the event of your death, the earliest of: (a) the last day of the period for which you had qualified for coverage; or (b) the date on which the spouse remarries;
- The date the Dependent no longer qualifies as an eligible Dependent;
- The date the Dependent enters the Armed Forces on full-time active duty;
- The date the Dependent becomes covered under the Plan as an Employee;
- The date of the Dependent's death; or
- The date the Plan is terminated or amended to exclude coverage for the Dependent.

Self-Pay Continuation of Coverage for Surviving Spouses of Active Employees

If you die while covered under the Plan, your covered surviving spouse will have the option to self-pay to continue coverage for Dental and Vision Benefits if your spouse:

- Is 50 years of age or older at the time of your death; and
- Notifies the Fund Office in writing by the later of: (a) the date the spouse's eligibility for any continuation of coverage under the Plan terminates; or (b) 90 days after your death.

This continuation of coverage will end on the earliest of the dates on which the spouse:

- Fails to pay timely the required self-payments;
- Becomes eligible for Medicare benefits;
- Becomes eligible for another group health plan; or
- Remarries.

This coverage does not apply to the spouse's Death Benefit or to coverage for Dependent children.

Eligibility for Retired Employees and Their Dependent Spouses

If you retire under the provisions of the New Orleans Employers – ILA, AFL-CIO Pension Plan ("Pension Plan"), you and your eligible Dependent spouse will be eligible for the Death Benefit coverage for Retired Employees Only, as described in the Schedule of Benefits. Retiree Death Benefits under the Plan are not vested benefits guaranteed upon retirement and may be amended, reduced, or eliminated by the Trustees at any time.

Normal, Vested or Early Retirement

If you satisfy each of the following requirements, you and your Dependent spouse will be eligible for the Death Benefit coverage for Retired Employees Only, as described in the Schedule of Benefits:

- You retire with a pension benefit under the Pension Plan on or after January 1, 2006;
- You are covered under the Plan at the active Employee level on the effective date of your retirement;
- You have 25 or more years of creditable employment under the Pension Plan for pension benefit purposes; and
- You are age 58 or older. (If you are not age 58 or older on the effective date of your retirement, you and your Dependent spouse's eligibility for the Death Benefit coverage will be effective on the day you become 58 years of age).

If you: (i) retire with a pension benefit under the Pension Plan on or after January 1, 2006; (ii) are covered under the Plan at the active Employee level on the effective date of your retirement; and (iii) have fewer than 25 years of creditable employment under the Pension Plan, you will be eligible for the Death Benefit coverage for Retired Employees Only, as described in the Schedule of Benefits, when you become eligible for Medicare. Your Dependent spouse will be eligible for the Death Benefit coverage for Retired Employees Only, as described in the Schedule of Benefits, on the day he or she becomes eligible for Medicare, or, if later, on the day you become eligible for Medicare.

Disability Retirement

If you satisfy either of the following requirements, you and your Dependent spouse will be eligible for the Death Benefit coverage for Retired Employees Only, as described in the Schedule of Benefits:

- You are covered under the Plan as an active Employee on the effective date of your retirement with a Disability Pension under the Pension Plan, or qualify for active Employee coverage under the Plan for the calendar year after the year your Disability Pension is approved; or

- You retire with a Disability Pension under the Pension Plan and have Employment in the Industry or Contribution Credit Hours of 500 or more in the Plan Year in which your pension is approved or in the Plan Year immediately before it.

Foreman

If you retire as a Foreman-Employee under the Pension Plan and your last day of work before retirement was Employment in the Industry, you and your Dependent spouse will be eligible for the Death Benefit coverage for Retired Employees Only, as described in the Schedule of Benefits, if you meet the eligibility requirements for Retired Employees.

Commencement of Coverage for Retired Employees and Their Eligible Dependent Spouses

Retiree coverage for you and your eligible Dependent spouse will begin on the later of the following dates:

- Your approved retirement date as determined by the Board of Trustees of the Pension Plan; or

- January 1 of the calendar year following the December 31 termination date of your coverage at the active Employee level (including any one-year extension at retirement described on page 22); or

- For Retired Employees and Dependent spouses of Retired Employees with 25 or more years of creditable employment under the Pension Plan only who are eligible at retirement but for the age requirement, the day you become 58 years of age; or

- For Retired Employees with fewer than 25 years of creditable employment under the Pension Plan only, the day you become eligible for Medicare; or

- For Dependent spouses of Retired Employees with fewer than 25 years of creditable employment under the Pension Plan only, the day he or she becomes eligible for Medicare, or, if later, the day you become eligible for Medicare.

Termination of Retired Employee's Coverage

Your retiree coverage will terminate on the earliest of the following dates:

- The date you die;

- The date the Plan terminates or the date the Plan is amended to exclude coverage for Retired Employees; or

- The date you return to work in one of the following classifications, in which case termination will be immediate and permanent:

    (1) Work in the New Orleans/Baton Rouge area that is not Covered Employment and is the type of work traditionally covered by the Collective Bargaining Agreement; or

(2) Work as a stevedore foreman for an employer who is not an Employer signatory to the trust agreement for the Fund.

Termination of Coverage for Dependent Spouses of Retired Employees

Coverage under the Plan for your Dependent spouse will end on the earliest of the following dates:

- The date your coverage ends for reasons other than your death;
- In the event of your death while covered, one (1) year from the first day of the month following the month in which you die;
- The date the Dependent spouse no longer qualifies as an eligible Dependent;
- The date of the Dependent spouse's death; or
- The date the Plan terminates or the date the Plan is amended to exclude coverage for Dependent spouses of Retired Employees.

Continuation of Coverage Option Under COBRA for Active Employees and their Eligible Dependents

You will have the option to continue your Dental and Vision Benefits coverage on a self-payment basis, beyond the date it would otherwise terminate to the extent required by the federal law known as COBRA.

Qualifying Events and Qualified Beneficiaries

Under certain circumstances known as "qualifying events," you and/or your eligible Dependents will be entitled to continue Dental and Vision Benefits coverage beyond the date coverage would otherwise terminate. If you lose eligibility for coverage due to termination of employment for any reason (other than gross misconduct) or due to reduction in hours worked, or if your benefits would otherwise be reduced to the Retired Employee benefit level, you and/or your Dependents may elect to self-pay for up to 18 months of Dental and Vision Benefits coverage at the active Employee benefit level.

If your Dependent(s) lose Dental and Vision Benefits coverage due to your death or divorce or because the Dependent no longer qualifies as a Dependent, the Dependent(s) may elect to self-pay for up to 36 months of Dental and Vision Benefits coverage at the active Employee benefit level.

If you experience a termination of employment, reduction in hours or reduction in benefits qualifying event that would otherwise trigger the right to elect 18 months of COBRA coverage and such qualifying event occurs after you first become entitled to Medicare benefits (enrollment in Medicare Part A or Part B), the maximum period of COBRA coverage available to your Dependents will be 36 months from the date you become entitled to Medicare or, if longer,

18 months from such qualifying event. If the qualifying event precedes the date you first become entitled to Medicare, the maximum COBRA coverage period will be the 18, 29 or 36 month period as determined under the general COBRA rules.

If a qualified beneficiary experiences a second qualifying event while receiving COBRA coverage, his or her maximum period of COBRA coverage, by reason of such second qualifying event, will be 36 months from the date COBRA coverage originally began due to the first qualifying event. The qualified beneficiary must notify the Fund Office in the event of such second qualifying event. Notice to the Fund Office must be in writing and must be received by the Fund Office within 60 days of such second qualifying event. If the Fund Office is not so notified, any Dependent(s) affected by the second qualifying event will not be eligible to elect COBRA coverage.

A "qualified beneficiary" under COBRA is any Employee or Dependent who, on the day before the qualifying event, has Dental and Vision Benefits coverage under the Plan, would otherwise lose such coverage due to the qualifying event and timely elects to receive COBRA coverage, as well as any Dependent child who is born to or placed for adoption with a covered Employee during the period of COBRA coverage.

If a qualified beneficiary with COBRA coverage acquires a Dependent, the Dependent may be added to Dental and Vision Benefits coverage for the remainder of the COBRA coverage period. If a qualified beneficiary has a Dependent who was eligible but not enrolled in the Plan at the time the qualified beneficiary enrolled for COBRA coverage because the Dependent had other group health coverage at that time, and the Dependent loses the other coverage due to exhaustion of COBRA coverage or, for non-COBRA coverage, due to loss of eligibility or termination of employer contributions, the qualified beneficiary may add the Dependent to his or her Dental and Vision Benefits coverage for the remainder of the COBRA coverage period, within 30 days after the Dependent's loss of the other coverage.

Social Security Disability

If an Employee or Dependent with 18 months of COBRA coverage by reason of an Employee's termination of employment, insufficient hours or reduction of benefits qualifying event, is determined by Social Security to have been totally disabled at any time during the first 60 days of COBRA coverage, the disabled individual and all other individuals with COBRA coverage by reason of the same qualifying event may extend their COBRA coverage to 29 months or, if earlier, through the last day of the month which includes the 30th day after a final determination by Social Security that the individual is no longer disabled.

To qualify for this 11-month extension, you must notify the Fund Office of the Social Security disability determination. Notice to the Fund Office must be in writing and must be received by the Fund Office before expiration of the initial 18-month COBRA coverage period and within 60 days after the date of issuance of the Social Security determination. A copy of the Social Security disability determination must be submitted to the Fund Office along with the notice.

You must also notify the Fund Office of a Social Security determination that an individual is no longer disabled. Notice to the Fund Office must be in writing and must be received by the Fund

Office within 30 days after the Social Security determination that the individual is no longer disabled.

The Cost

The COBRA coverage option requires that Participants pay the cost determined by the Trustees, which will not exceed the actual cost of the group Dental and Vision Benefits coverage, plus any additional amounts permitted by law. The first payment must be made no later than 45 days after the date COBRA coverage is elected and must cover the cost for coverage from the date it would otherwise have terminated through the end of the month in which payment is made. All subsequent payments are payable on a monthly basis and due by the first day of each month for which the payment is being made, subject to a 30-day grace period. The COBRA payment rates will remain constant for a 12-month period to the extent required by law, but otherwise will change as the cost of coverage changes. Specific information on the cost of COBRA coverage will be provided to those persons who become eligible for it.

Early Termination of COBRA Coverage

Your COBRA coverage will terminate earlier than the 18, 29 and 36-month maximum coverage periods described above upon the earlier of:

- The date, after COBRA coverage is elected, on which you first become covered under Medicare or another group health plan that does not have a limitation or exclusion for any pre-existing condition that affects you or, if it does contain such a limitation or exclusion, until the limitation or exclusion no longer applies or, if earlier, until you no longer suffer from the condition;

- The first day of the period for which you fail to pay timely a COBRA self-payment; or

- The date the Plan terminates.

If your COBRA coverage will terminate before the end of the maximum coverage period, the Plan will send you a written notice as soon as practicable following the Plan's determination that COBRA coverage will terminate. The notice will set out why COBRA coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Notification and Election Requirements

The Plan will notify you and your Dependents of your rights under COBRA when you first become covered under the Plan. You and your Dependents must notify the Fund Office in the event a Dependent child loses eligibility status under the Plan or in the event of your divorce. Notice to the Fund Office must be in writing and must be received by the Fund Office within 60 days after the date on which the qualifying event occurs. If the qualifying event is your divorce, a copy of the divorce decree must be submitted to the Fund Office along with the notice. If the Fund Office is not so notified, your Dependent(s) affected by such qualifying event will not be eligible for COBRA coverage.

In the event of a loss of coverage due to your death, reduction in hours worked, termination of employment or reduction of benefits due to retirement, the Fund Office will identify persons eligible for COBRA coverage and will notify them of their rights to continue coverage.

Once persons eligible for COBRA coverage have been identified, the Fund Office will send them specific information on when and how to elect COBRA coverage, including the cost of that coverage. Notice given to you or your Dependent spouse is deemed to be notice to all affected Dependent children living with you or your Dependent spouse. You and/or your Dependents will then have 60 days after the later of (a) the date Dental and Vision Benefits coverage will otherwise terminate by reason of the qualifying event, or (b) the date you and/or your Dependents are notified of the right to elect COBRA coverage, within which to elect to continue coverage.

Continuation of coverage is optional for you and your Dependent. Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA coverage. For example, both the Employee and the Employee's spouse may elect continuation coverage, or only one may elect continuation coverage.

If you waive COBRA coverage during the 60-day election period, you may revoke the waiver and elect COBRA coverage at any time during the 60-day election period; however, COBRA coverage will be provided only from the date of revocation and not retroactive to the loss of coverage.

If you or your Dependents provide notice to the Plan of your divorce, a Dependent ceasing to be covered under the Plan as a Dependent, or a second qualifying event, but you are not entitled to COBRA coverage, the Plan will send you a written notice stating the reason why you are not eligible for COBRA coverage.

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan informed of the current addresses of all Participants under the Plan who are or may become qualified beneficiaries. You should also keep copies, for your records, of any notices you send to the Plan.

Plan Contact Information

Information about the Plan and COBRA coverage can be obtained upon request from:

Administrative Manager
The New Orleans Employers – International Longshoremen's Association, AFL-CIO Welfare Plan
147 Carondelet Street, Suite 300
New Orleans, Louisiana 70130
(504) 525-0309

Certificate of Creditable Coverage

When your Dental and Vision Benefits coverage ends or you become eligible for COBRA coverage, you will be provided with a Certificate of Creditable Coverage indicating the period during which you had Dental and Vision Benefits coverage under the Plan. If a Dependent's

Dental and Vision Benefits coverage under the Plan terminates or the Dependent becomes eligible for COBRA coverage at a different time or for a different reason than the Employee and the Plan is notified of that fact, a separate Certificate of Creditable Coverage will be provided to the Dependent or the Dependent's guardian. You and your Dependents may also request a copy of a Certificate of Creditable Coverage at any time within 24 months after your Dental and Vision Benefits coverage has terminated. The Certificate of Creditable Coverage may be used to reduce or eliminate a pre-existing condition limitation period under a new health plan or arrangement under which you or your Dependents become covered.

DEATH BENEFITS
(ACTIVE EMPLOYEES AND RETIRED EMPLOYEES)

The Plan will provide on behalf of each eligible active and Retired Employee a Death Benefit in the amount specified in the Schedule of Benefits. The Death Benefit is payable to your Beneficiary upon your death while covered for the Death Benefit. The Death Benefit coverage offered through the Plan is fully insured through an insurance company ("the Company") and is subject to the terms and conditions of the insurance policy in effect at the time of death.

When You Become Insured for Death Benefits

Refer to Eligibility section beginning on page 17.

Continuance of Benefits for Retired Employees Who Qualify as Active Employees

If you are a Retired Employee who, at retirement, has earned sufficient hours to qualify for a one year extension of coverage at the active Employee level, as described on page 22, your Death Benefit coverage at the active Employee level of benefits will continue until your active Employee benefits expire.

Continuance of Benefits for Retired Employees

If you are a Retired Employee who qualifies for retiree coverage under the Retired Employees eligibility rules, you are eligible for Death Benefit coverage at the Retired Employee level of benefits until your retiree coverage terminates or until your death.

Payment and Amount of Death Benefit

If you die while you are covered, the Death Benefit coverage in force at the time of your death, as shown in the Schedule of Benefits, will be paid to your Beneficiary.

Beneficiary Provisions

Change of Beneficiary

You may make Beneficiary changes at any time, without the consent of the previously named Beneficiary. Such changes must be requested in writing on a form furnished by or satisfactory to the Company. Any change will take effect upon receipt of the signed form by the Company or by your Field Office.

Payment to Beneficiary

The Death Benefit will be payable in accordance with the Beneficiary designation effective at the time of payment.

If you have named more than one Beneficiary, each surviving Beneficiary will share equally, unless otherwise indicated by you when the Beneficiaries were named.

If no Beneficiary designation is effective at your death, or if no designated Beneficiary is living at your death, payment will be made to the first surviving class in the following order:

- Your surviving spouse;
- Your children, in equal shares;
- Your parents, in equal shares;
- Your brothers and sisters in equal shares; or
- The executors or administrators of your estate.

In order to determine which class of individuals is entitled to the Death Benefit, the Plan may rely on an affidavit made by any individuals listed above. If payment is made based on such affidavit, the Plan will be discharged of its liability for the amount paid, unless written notice of claim made by another individual listed above is received before payment is made.

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

Before payment to your Beneficiary is made, the Plan will require due proof of your death.

Facility of Payment

If an individual appears to the Company to be equitably entitled to compensation because he or she has incurred expenses on behalf of your burial, the Company may pay to such individual the expenses incurred up to $500. Such payment, however, shall not exceed the amount due under the Plan. The Plan will be fully discharged of its liability for any amount of benefit so paid in good faith.

Termination of Your Death Benefit Coverage

Your Death Benefit coverage will terminate when your coverage as an active Employee or Retired Employee terminates, without regard to any extended coverage provisions that apply only to the Dental and Vision Benefits. You may, however, qualify for a continuance of your Death Benefit coverage to the extent described below.

Continuance of Death Benefit Coverage in the Event of Total Disability (Active Employees Only)

Your Death Benefit coverage may be continued, without any premium payment required, in the event you become Totally Disabled and meet other requirements. “Totally Disabled” (or “Total Disability”) means your complete inability, due to Injury or Illness, to engage in any business,

occupation, or employment, even on a part-time basis, for which you are qualified, or become qualified, by reason of education, training, or experience, for pay, profit, or compensation. Any continuation of Death Benefit coverage due to Total Disability begins on the date you cease to be an Active Employee or, if later, the date you exhaust all accumulated eligibility under the Plan.

Continuance of Death Benefit Coverage in the Event of Total Disability Commencing before 60th Birthday (Active Employees Only)

If, on the date you cease to be covered as an active Employee under the Plan, you are Totally Disabled, and such Total Disability commenced before your 60th birthday and continues without interruption until your death, the Death Benefit applicable to the amount of coverage in force on the date you became Totally Disabled will be paid to your Beneficiary, provided:

- You have not been classified as a Retired Employee;
- You have not been classified as a Retired Employee with active benefits;
- Your death occurs more than 31 days after termination of your coverage; and
- Due proof of your Total Disability is received by the Company or by your Field Office as follows:

  (1) initial proof of disability and its uninterrupted continuance for a period of at least nine (9) months must be received by the Company or by your Field Office within 12 months from the date your coverage as an Active Employee would otherwise end; and

  (2) subsequent proof of the uninterrupted continuance of disability must be received by the Company or by your Field Office within three (3) months prior to each anniversary of the date the Company or your Field Office receives the initial proof.

  If you die, the Company will also require written proof that you were continuously Totally Disabled from the date of the last anniversary of the Company's or your Field Office's receipt of the proof of disability through the date of your death.

It is your responsibility to submit the required proof of disability to the Company or to your Field Office on a timely basis. The Company will not request such proof. The Company will give written notice to you within 10 days of receipt of an "Application for Waiver." The notice will indicate whether your application is approved or disapproved. If it is disapproved, the notice will give the reasons for disapproval.

If you are denied continuation of your Death Benefit coverage and you did not exercise your right to convert to an individual policy of life insurance, you may be entitled to the same conversion rights that applied on the date your Death Benefit coverage would have terminated in the absence of this continuation provision.

If you hold an individual conversion policy and are denied continuation of your group life insurance, you may continue your coverage under the individual conversion policy.

One Year Continuance for Total Disability Commencing on or after 60th but before 65th Birthday (Active Employees Only)

If, on the date you cease to be covered as an active Employee under the Plan, you are Totally Disabled, and such disability commenced on or after your 60th birthday but before your 65th birthday and continues without interruption until your death, the Company will pay the Death Benefit applicable to the amount of coverage in force on the date you became Totally Disabled, provided:

- You have not been classified as a Retired Employee;
- You have not been classified as a Retired Employee with Active Employee benefits;
- Your death occurs more than 31 days but within 12 months after termination of your coverage; and
- Due proof of your Total Disability, of its uninterrupted continuance and of your death is received by the Company or by your Field Office not later than 12 months after your death.

Limitations

Any continuance under these provisions will automatically terminate on the earliest of:

- cessation of Total Disability (as defined above);
- failure to furnish any required proof of the uninterrupted continuance of Total Disability or to submit to any required examination by a Physician;
- becoming a Retired Employee, or a Retired Employee with active benefits; or
- in the event of the one-year continuance for Total Disability commencing on or after your 60th but before your 65th birthday, the end of the 12 months following termination of your coverage.

The amount of the Death Benefit payable under these provisions will be reduced by the amount payable under any policy obtained under the conversion privilege.

These provisions do not extend your Accidental Death and Dismemberment Benefits or Spousal Death Benefits, which terminate on the date your coverage as an active Employee ends.

Conversion Privilege for Death Benefit

The conversion privilege described in this section is available during the 31-day period beginning with the termination of your Death Benefit coverage, where such termination is due to:

- Termination of your status as an eligible Employee; or

- Termination of the policy maintained by the Plan to provide the Death Benefit coverage or amendment of it to cancel insurance on the class of Employees to which you belong, provided in either case you had been continuously covered for the Death Benefit for at least five years as a result of Employment in the Industry.

To qualify for a conversion policy, you must submit a written application to the Company and pay the first premium during such 31-day period, and the Company will issue to you an individual policy of life insurance. No evidence of insurability will be required for the converted life insurance coverage.

The policy will be on your life and may be in any one of the forms of life insurance then customarily issued by the Company, except term insurance. The amount to be converted must meet the Company's minimum requirements for the policy you select.

The face amount of the converted policy will, at your option, be equal to or less than the Death Benefit in force on your life immediately before termination of your coverage, less the amount of any life insurance coverage for which you are or become eligible as an Employee within 31 days after termination. However, where the conversion privilege is available because of termination or amendment of the policy, the amount of insurance on your life under the converted policy cannot exceed the amount described in the preceding sentence or, if less, $2,000.

No additional insurance benefits will be included in the converted policy, except with the approval of the Company at the time you apply for the converted policy and subject to the furnishing of such requirements as the Company will then consider necessary.

The new policy will take effect at the end of such 31 days if you are then living and the first premium for it has previously been paid to the Company at its Home Office.

Death Benefit During Conversion Period

If you die during the 31-day conversion period, the maximum amount of life insurance that you would have been eligible to convert will be paid as a benefit to your Beneficiary, whether or not you applied for conversion or paid any premiums.

Income Option For Settlement of Death Benefit Proceeds

Death Benefits will be paid to your Beneficiary in one lump sum, unless you have elected to have the proceeds paid in installments under an optional plan that is then being offered by the Company. The details of these settlement options may be obtained from the Company or through your Field Office. If you do not elect a settlement option for payment of Death Benefits, your Beneficiary may do so after your death.

SPOUSAL DEATH BENEFITS
(ACTIVE EMPLOYEES AND RETIRED EMPLOYEES)

The Plan will provide, on behalf of the Dependent spouse of each eligible active and Retired Employee, Death Benefit coverage in the amount shown in the Schedule of Benefits. The Death Benefit will be paid to you in the event of your Dependent spouse's death while covered. This spousal Death Benefit is also fully insured with the Company and is subject to the terms and conditions of the insurance policy in effect at the time of death.

In the event you are no longer living at the time your spouse dies while covered for the Death Benefit (see Eligibility for Dependents of Active Employees on page 22 or Termination of Coverage for Dependent Spouses of Retired Employees on page 26), the Company will honor a designation of Beneficiary made by your spouse after your death, filed at its Home Office or at your Field Office. In the absence of such designation, your spouse's Death Benefit will be paid to the first surviving class in the following order:

- Your children, in equal shares;
- Your parents, in equal shares;
- Your brothers and sisters in equal shares; or
- The executors or administrators of your estate.

In order to determine which class of individuals is entitled to the Death Benefit, the Plan may rely on an affidavit made by any individuals listed above. If payment is made based on such affidavit, the Plan will be discharged of its liability for the amount so paid, unless written notice of claim is made by another individual listed above is received before payment is made.

Before making payment, the Plan will require due proof of the death of your insured spouse.

For the purpose of this spousal Death Benefit, the provisions of the Eligibility section of this booklet relating to Dependents will be applicable to the extent they apply to your spouse.

If your Dependent spouse's Death Benefit coverage terminates, he or she will be entitled to convert to an individual life insurance policy on the same basis as you.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
(ACTIVE EMPLOYEES ONLY)

The Plan provides on behalf of each eligible active Employee an Accidental Death and Dismemberment Benefit in the amount specified in the Schedule of Benefits, payable if such Employee sustains loss of life or dismemberment from accidental bodily Injury. The dismemberment benefit covers loss of both hands, loss of both feet, loss of sight of both eyes, loss of one hand and one foot, loss of one hand or one foot and sight of one eye, loss of one hand or one foot, and loss of sight of one eye. The Accidental Death and Dismemberment Benefit is insured through the Company and is subject to the terms and conditions of the insurance policy in effect at the time of the accident.

Amount of Benefit

If, as a direct result of an accident that occurs while you are covered for this benefit, you suffer a covered loss within 180 days after the accident, the Plan will pay you the benefit shown in the Schedule of Benefits. If, however, you suffer a loss of life, the benefit will be paid to your Beneficiary who will be determined in the same manner as for the Death Benefit.

If more than one (1) covered loss is suffered as a result of any one accident, not more than the Accidental Death and Dismemberment Maximum shown in the Schedule of Benefits will be payable.

Loss of hand or foot means complete severance at or above the wrist or ankle joint. Loss of sight means its total and irrecoverable loss beyond remedy by surgery or other means.

If any benefit is payable to your estate or to an individual who is a minor or otherwise not competent to give a valid release, the Plan may pay such benefit up to an amount of $1,000 to any relative by blood or marriage or to any other person or entity that is deemed by the Plan to be entitled to such benefit.

Exclusions and Limitations

No benefits will be paid for any loss that is caused or contributed to, directly or indirectly, by any of the following:

- bodily or mental Illness or disease of any kind;
- ptomaine or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- suicide or attempted suicide while sane or insane;
- intentional self-inflicted Injury;
- participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion;

- war or act of war, declared or undeclared; or any act related to war, or insurrection;
- medical or surgical treatment of an Illness or disease;
- service in the armed forces of any country while such country is engaged in war;
- police duty as a member of any military, naval or air organization;
- travel or flight in or descent from any kind of aircraft as a passenger, pilot, crew member or participant in training that is owned, operated, or leased by or on behalf of the Fund, an Employer or the armed forces; or being operated for any training or instructional purpose;
- intake of any drug, medication or sedative unless prescribed by a Physician, or the intake of any alcohol in combination with any drug, medication or sedative;
- any poison or gas voluntarily taken, administered, absorbed, or inhaled; or
- driving while intoxicated as defined by applicable state law.

TEMPORARY DISABILITY INCOME BENEFITS
(ACTIVE EMPLOYEES ONLY)

If you are an active Employee and you become "Totally Disabled" while covered under the Plan, the Plan will pay you a Temporary Disability Income Benefit, subject to the provisions, exclusions and limitations of the Plan. "Totally Disabled" or "Total Disability" means you can perform no duty pertaining to your occupation as a result of non-occupational accidental bodily injuries, sickness or pregnancy.

Amount of Payments

The Temporary Disability Income Benefit is payable based on the weekly rate shown in the Schedule of Benefits.

When Payments Begin

Payment will be made for each day of Total Disability beginning with the eighth day of such disability. If benefits are payable for a period of less than one (1) week, the weekly rate will be prorated on the basis of seven (7) days per week.

Duration of Payments

Payments will continue to be made while you remain continuously Totally Disabled, but not for more than 26 weeks for any one continuous period of Total Disability.

Successive Total Disabilities

Successive periods of Total Disability will be considered one continuous period of Total Disability except where they are due to entirely unrelated causes and are separated by complete recovery and one week during which you are recorded as being available and capable of working on a full-time basis for an Employer.

Exclusions and Limitations

No benefits will be payable for any period during which you are not under the care of a Physician, or for any disability resulting from:

- Accidental bodily injury arising out of or in the course of any employment as an active Employee;
- Sickness for which you are entitled to benefits under Federal or State Workers' Compensation Acts or similar legislation;
- Self-inflicted injury; or
- Commission of a felony.

Temporary Disability Income Benefits will not be payable for any Total Disability resulting from substance abuse or chemical dependency unless you voluntarily confine yourself to an appropriate facility for the treatment of substance abuse or chemical dependency. However, if you incur an accidental injury at a work site, and are determined to have a substance abuse or chemical dependency disability, Temporary Disability Income Benefits will not be payable even if you voluntarily confine yourself to a facility for the treatment of substance abuse or chemical dependency following the accident.

Additionally, Temporary Disability Income Benefits will not be payable during any period in which you are receiving unemployment benefits or Worker's Compensation benefits or are "Employed in the Industry" as defined in the New Orleans Employers – ILA, AFL-CIO Pension Plan.

DENTAL BENEFITS
(ACTIVE EMPLOYEES AND ELIGIBLE DEPENDENTS)

Dental Benefits are designed to encourage you to obtain preventive dental services and to reimburse your eligible Dental Expense Charges incurred while you are covered under the Plan. After you have satisfied your Deductible (if any), the Plan will pay the applicable coinsurance for Dental Expense Charges up to the applicable Calendar Year Maximum or Lifetime Maximum per person, as shown in the Schedule of Benefits.

Calendar Year Deductible

The Calendar Year Deductible is the amount of Dental Expense Charges that you must incur and pay during a calendar year for the types of services, supplies and treatment to which the Deductible applies before those types of Dental Expense Charges incurred during the calendar year are payable. The Calendar Year Deductible amount is shown in the Schedule of Benefits. You and each covered Dependent must satisfy a separate Calendar Year Deductible.

There is no Calendar Year Deductible for Type I (Preventive) or Type IV (Orthodontic) Dental Expense Charges.

The Calendar Year Deductible for Type II (Basic) and Type III (Major) Dental Expense Charges is combined so that you must satisfy only one Calendar Year Deductible for both types of Dental Expense Charges incurred during a calendar year.

Any Dental Expense Charges incurred during the last three months of a calendar year that are applied against your Calendar Year Deductible may be carried over to the following calendar year and applied to your Calendar Year Deductible for the following year.

Lifetime Deductible (Orthodontic)

The Lifetime Deductible is the amount of Orthodontic Dental Expense Charges that a Dependent child must incur while covered before Dental Benefits are payable for Orthodontic Dental Expense Charges. The Lifetime Deductible, as shown in the Schedule of Benefits, applies only to Type IV (Orthodontic) Dental Expense Charges.

Coinsurance

After you or your Dependent has satisfied the applicable Calendar Year Deductible or Lifetime Deductible, as applicable, the Plan will pay the coinsurance percentage shown in the Schedule of Benefits for Dental Expense Charges incurred during the calendar year, or, as applicable, during your Dependent's lifetime while covered, up to the applicable Calendar Year Maximum or Lifetime Maximum. Type I (Preventive) Dental Expense Charges are not subject to coinsurance.

Calendar Year Maximum

The Calendar Year Maximum is the maximum Dental Benefit payable for Dental Expense Charges incurred during a calendar year for Types I (Preventive), II (Basic), and III (Major)

Dental Expenses Charges combined. The Calendar Year Maximum is not applicable to Type IV (Orthodontic) Dental Expense Charges.

Lifetime Maximum (Orthodontic)

The Lifetime Maximum, as shown in the Schedule of Benefits, is the maximum Dental Benefit payable during a Dependent child's lifetime for Type IV (Orthodontic) Dental Expense Charges.

Incurred Dates

A Dental Expense Charge must be incurred while you or your Dependent is covered, and it is incurred as of the date the procedure or service is rendered or the supply is furnished. As an exception, charges that are incurred for the following within 60 days after coverage has ended will be deemed incurred on the date described:

- With respect to fixed partial dentures, crowns, inlays, or onlays required to restore a tooth, on the first date of preparation of the tooth or teeth involved;

- With respect to removable partial or complete dentures, on the date the first impression was taken, provided the impressions are taken and the abutment teeth are fully prepared while there is coverage; or

- With respect to endodontics (root canal therapy), on the date the tooth was opened for root canal.

Eligible Dental Expense Charges

Dental Expense Charges for the following services, supplies, and treatment performed by a Dentist are eligible for the payment of Dental Benefits:

<u>Type I – Preventive</u>

- Oral Exams – Routine oral examinations including diagnosis, but not more than two such examinations with respect to the same covered individual during any calendar year.

- Prophylaxis – Including cleaning, scaling and polishing, but no more than two times in any calendar year with respect to the same covered individual.

- Fluoride Treatment – Limited to children fourteen (14) years of age and under.

- Space maintainers.

- Palliative emergency treatment.

- Emergency office visits.

Type II – Basic

- X-rays – including full mouth x-rays not to exceed one such series in any three year period, and bitewing x-rays not more than two times per calendar year.
- Laboratory tests and other diagnostic examinations.
- Simple (routine) extractions.
- Surgical extractions.
- Oral surgery.
- Alveolectomy.
- Anesthesia.
- Therapeutic injections.
- Restorations – fillings of amalgam or synthetic process but specifically excluding (i) posterior or anterior crowns of jackets, and (ii) initial placement of full or partial dentures and replacement of dentures and fixed bridge units.
- Denture repair and bridge repair.
- Endodontics.
- Periodontic.

Type III – Major

- Inlays.
- Onlays.
- Crowns.
- Prosthetics – including bridges and dentures:

  (1) The initial installation of, or the addition to full or partial dentures or fixed bridge work will be eligible provided: (a) it is required as a result of an extraction of one or more injured or diseased natural teeth; and (b) includes the replacement of such an extracted tooth. Dentures and bridgework will be considered initially installed if they do not replace any existing dentures or bridgework.

  (2) The replacement of a full or partial denture when required as a result of structural change within the mouth will be considered for payment provided the replacement is made more than five years after the date of the installation of such denture.

Type IV – Orthodontics (applicable to Dependent children only)

- Orthodontic appliances, including furnishing and attachment of any necessary orthodontic appliances, or replacement of damaged appliances.

- Orthodontic treatment performed pursuant to a written treatment plan submitted to the Plan and considered in accordance with the orthodontic coverage of this Plan.

Charges incurred for any one course of orthodontic treatment (including any orthodontic diagnosis, evaluation, and pre-orthodontic treatment, subject to the Reasonable and Customary standard) will be payable as follows:

The orthodontic Lifetime Deductible is applied to the eligible Dental Expense Charges for the orthodontic treatment plan, including the Dentist's initial visit charge, and then an initial payment will be made for 50% of the total charges for the orthodontic treatment plan including the Dentist's initial visit charge up to the Orthodontic Lifetime Maximum.

In no event will Dental Benefits be payable for any charges incurred for orthodontic services rendered prior to the effective date of the Dependent child's coverage.

All Dental Benefits payable for Type IV (Orthodontic) Dental Expense Charges are subject to the Orthodontic Lifetime Deductible and the Lifetime Maximum as shown in the Schedule of Benefits.

Dental Treatment Plan

The term "treatment plan" means the written statement of a Dentist on a form furnished by or satisfactory to the Plan in which the Dentist sets out findings from an examination, the Dentist's suggested plan of treatment, and the approximate cost and duration of such treatment.

You should submit a treatment plan to the Plan prior to beginning any course of treatment that can reasonably be expected to involve covered dental expenses in excess of $100.

Dental Examination By Plan

The Plan, at its own expense, will have the right and opportunity to have a Dentist examine you when, and as often as it may reasonably require in connection with a claim for Dental Benefits under this Plan.

Alternate Course of Dental Treatment

If alternate services are employed to treat a dental condition, the amount of Dental Expense Charges considered for payment will be limited to the amount that would have been incurred for services customarily employed in the treatment of the disease or injury and recognized by the dental profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account your total current oral condition.

Exclusions and Limitations – Dental Benefits

In no event will Dental Benefits be payable for any of the following:

- Any services for which no charge is made to you or your Dependent, or any charges for service or supplies that are obtained without cost in accordance with the laws or regulations of any government or government agency, except to the extent a charge is made that you or your Dependent is legally required to pay;

- Any charges for services of a Dentist or clinic contracted for or by an Employer, Union, employee benefit association, trust, or similar organization;

- Any charges for services made necessary as a result of your or your Dependent's commission of, or attempt to commit an assault, battery or felony (other than an act of domestic violence to the extent prohibited by HIPAA), or act of aggression, insurrection, rebellion, or participation in a riot, or resulting from an act of or in the course of war, declared or undeclared;

- Any charges for dental services for cosmetic purposes;

- Any charges for replacement of teeth unless the replacement satisfies the conditions listed in Eligible Dental Expense Charges, above;

- Any charges for dentures, crowns, inlays, onlays, bridgework or appliances or services for increasing vertical dimensions;

- Any charges for denture or bridgework adjustments within six months of the placement or adjustment of bridgework;

- Any charges for replacement of a lost or stolen prosthesis, or for a duplicate prosthesis;

- Any charges for sealants, or any charges for oral hygiene, dietary, or plaque control instructions and programs;

- Any charges for injury or disease arising out of or in the course of any occupation or any employment for compensation, profit or gain;

- Any charges for athletic mouth guards;

- Any charges for a temporary denture or bridge that, when combined with the charge for the permanent denture or bridge, exceeds the Reasonable and Customary amount payable for the permanent denture or bridge;

- Any charges made by a Dentist for your failure to appear as scheduled for an appointment;

- Any charges for implantology;

- Any charges for drugs, other than injectable antibiotics administered by a Dentist or Physician as a result of dental treatment;

- Any charges for procedures, services, or supplies, that do not meet accepted standards of dental practice, including charges for procedures, services or supplies that are experimental in nature;

- Any charges incurred while there is no coverage under the Plan; or

- Any charges for treatment not deemed necessary.

Extension of Dental Benefits

Dental Benefits are payable for Dental Expense Charges incurred following your termination of Dental Benefits coverage in the following circumstances, provided that such expenses would otherwise qualify as eligible:

- Charges for removal of a partial or complete denture if the impressions were taken and abutment teeth fully prepared while you were covered for Dental Benefits, provided the prosthetic device is installed or delivered to you within 60 days following termination of your coverage;

- Charges for a fixed partial denture, crown, inlay, or onlay required for the restoration of a tooth if the tooth was prepared for the crown while you were covered for Dental Benefits and the fixed partial denture, crown, inlay or onlay is installed within 60 days following termination of your coverage;

- Charges for root canal therapy if the tooth was opened while you were covered for Dental Benefits under the Plan and treatment is completed within 60 days following termination of your coverage.

Under no other circumstances will Dental Benefits be payable for expenses incurred after coverage for Dental Benefits has terminated.

VISION BENEFITS
(ACTIVE EMPLOYEES AND ELIGIBLE DEPENDENTS)

The Plan provides Vision Benefits for eye examinations and glasses and frames or contact lenses. You may receive services and obtain eyewear from any licensed vision care provider. The Plan has entered into a managed vision care contract with Davis Vision, Inc. so that you may participate in the Davis Vision network of vision care providers. The Vision Benefits for services and eyewear obtained through the Davis Vision network are subject to the terms of that contract and are described below under "In-Network Services." The Vision Benefits for services and eyewear obtained from a provider who does not participate in the Davis Vision network are described below under "Out-of-Network Services."

In-Network Services

The Plan provides the following Vision Benefits when you receive services and obtain eyewear from a vision care provider participating in the Davis Vision network. You may obtain, without charge, a list of the providers participating in the Davis Vision network upon request to the Administrative Manager.

Standard Copayments

You may obtain the following vision care services and eyewear from Davis Vision network providers for the standard copayments shown in the Schedule of Benefits. The network provider will explain which frames and lenses are available to you for the standard copayment. The standard copayments are payable by you to the network provider.

- An eye examination, including dilation as professionally indicated;
- Frames on the Davis Vision formulary, which includes the Designer Selection frames from the "Tower Collection";
- Spectacle lenses and coatings that as per the Davis Vision formulary or network provider are available with the frames described above; and
- Contact lenses (in lieu of eyeglasses) on the Davis Vision formulary, such as standard, soft, daily-wear, disposable or planned replacement contact lenses for most prescriptions.

Retail Credits

You may obtain the following vision care services and eyewear from Davis Vision network providers and receive a retail credit as shown in the Schedule of Benefits. The network provider will explain which frames and lenses are available for a retail credit.

- Frames from the network provider's private collection that are not on the Davis Vision formulary;

- Spectacle lenses and coatings not on the Davis Vision formulary, including: plastic or glass single vision, bifocal or trifocal lenses; glass grey #3 prescription lenses; oversize lenses; post-cataract (lenticular) lenses; fashion, sun or gradient tinted plastic lenses; ultraviolet (UV) coating; scratch-resistant coating; polycarbonate lenses; photo-grey extra (sun-sensitive) glass lenses; blended invisible bifocals; and progressive addition multi-focal lenses; and

- Contact lenses (in lieu of eyeglasses) that are not on the Davis Vision formulary, such as toric or gas permeable, fitting fees and recommended follow-up care.

Additional Copayments

You may obtain the following vision care services and eyewear from Davis Vision network providers for an additional copayment (in addition to the standard copayment) as shown in the Schedule of Benefits:

- Optional frames, lens types and lens coatings on the Davis Vision formulary, such as Premier frames from the "Tower Collection"; standard and premium ARC (anti-reflective coating); polarized lenses; transitions (sun-sensitive) plastic lenses; high-index (thinner and lighter) lenses; and intermediate vision lenses.

The network provider will explain which frames and lenses are available to you for the additional copayment. The standard copayments and additional copayments are payable by you to the Davis Vision network provider.

Contact Lenses for Keratoconus

Expenses for contact lenses that are medically necessary for the correction of keratoconus are covered up to the maximum amount shown in the Schedule of Benefits.

Laser Vision Correction Services

You may obtain discounts for laser vision correction services through a network of experienced, credentialed surgeons.

Out-of-Network Services

The Plan will reimburse you for expenses incurred for the following vision care services and eyewear obtained from an out-of-network licensed vision provider, up to the maximum amounts shown in the Schedule of Benefits.

- Eye examination;

- Single vision lenses;

- Bifocal lenses;

- Trifocal lenses;

- Frames;
- Contact lenses (in lieu of frames and lenses); and
- Contact lenses medically necessary for the correction of keratoconus.

When you choose an out-of-network provider, you must pay the provider directly for all charges and submit your claim for reimbursement to:

Vision Care Processing Unit
P.O.Box 1525
Latham, NY 12110

Benefit Period

Vision care services and eyewear materials may be obtained only once every 24 months, whether from an in-network or out-of-network provider.

Mail Order Replacement Contact Lenses

The Plan offers free membership and access to *Lens 1-2-3*, a mail order replacement contact lens service. You may call 1-800-LENS-123 (1-800-536-7123) for more information.

Exclusions

The following services and supplies are not covered for Vision Benefits, regardless of whether they are provided by an in-network provider or out-of-network provider:

- Medical treatment of eye disease or injury;
- Vision therapy, orthoptics or vision training and any associated supplemental testing;
- Special lens designs or coating, other than those specifically described as covered;
- Replacement of lost or broken eyewear;
- Non-prescription (plano) lenses;
- Two pairs of eyeglasses in lieu of a bifocal;
- Eyeglasses and contact lenses during the same benefit period (within 24 months of each other);
- Corrective vision services, treatment and materials of an experimental nature;
- Services or materials covered under Worker's Compensation;

- Safety glasses, or any eye examinations or corrective eyewear required by an employer as a condition of employment;

- Services or supplies provided by any individual who is not an optometrist, ophthalmologist, or optician acting within the scope of his or her license;

- Expenses resulting from participation in a riot or commission of a felony (other than an act of domestic violence to the extent prohibited by HIPAA);

- Services or supplies provided or paid for by the federal government or its agencies;

- Services or supplies furnished without charge;

- Expenses incurred after Vision Benefits coverage ends;

- Radial keratotomy and implants; and

- Expenses not specifically listed as covered.

COORDINATION OF BENEFITS WITH OTHER PLANS AND SUBROGATION

Coordination of benefits ("COB") applies when a Participant has health care coverage under more than one plan, as defined below. COB rules are used to determine whether this Plan is a primary plan or secondary plan when compared to another plan covering the person. When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another plan and may be reduced so that payments from all group plans do not exceed 100 percent of the total allowable expense. In no event will the amount of benefits paid under this Plan exceed the amount that would have been paid if there were no other plan involved.

If you are eligible for Medicare, this Plan will be coordinated with Medicare Parts A and B whether or not you have enrolled in Part B. This means that if you fail to enroll in Part B, you will be required to pay a larger portion of the bill that would otherwise be payable by Medicare.

Definitions

"Allowable expense" means a health care service or expense that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense.

"Claim determination period" means the calendar year, but does not include any part of a year during which a person has no coverage under this Plan.

"Plan" means any of the following that provides benefits or services for medical or dental care or treatment: (a) group insurance or any coverage for individuals in a group (whether insured or uninsured); (b) hospital indemnity benefits in excess of $300 per day or medical care components of group long-term care contracts; (c) medical benefits under group or individual automobile contracts; and (d) Medicare or other governmental benefits as permitted by law. "Plan" does not include: (a) individual or family insurance or other coverage; (b) hospital indemnity insurance of $300 or less per day; (c) school accident type coverage; (d) benefits for nonmedical components of group long-term care policies; (e) Medicare supplement policies; (f) Medicaid policies; and (g) coverage under other governmental plans unless prohibited by law.

Order of Benefit Determination Rules

When two or more plans pay benefits, the first of the following rules that applies determines the order in which the plans pay or provide benefits. The plan that is determined to be the primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The secondary plan may consider the benefits paid or provided by another plan in determining its benefits.

<u>Plan Without Model COB</u>

A plan that does not contain a coordination of benefits provision consistent with the model COB provisions under Louisiana law is primary.

Nondependent/Dependent

The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber or retiree) is primary, and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (for example, a retiree), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan

The order of benefits when a child is covered by more than one plan is as follows:

(1) if the parents are either married or not separated (whether or not they ever have 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 is the plan of the parent whose birthday is earlier in the year or, if both parents have the same birthday, the plan that covered either of the parents longer;

(2) if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree; and

(3) if the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is as follows: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

Active/Inactive Employee

The plan that covers a person as an employee who is neither laid off nor retired is the primary plan. The same rule holds true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage

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

Longer/Shorter Coverage Period

The plan that has covered the person as an employee, member, subscriber or retiree longer is primary.

Default Rule

If the preceding rules do not determine the primary plan, the allowable expenses are shared equally between the plans; however, in no event will this Plan pay more than it would have paid had it been primary.

When this Plan is the secondary plan and its payment is reduced to consider the primary plan's benefits, a record is kept of the reduction. This amount will be used to increase this Plan's payments on the covered individual's later claims in the same calendar year, to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and the others.

Right of Subrogation/Reimbursement

The Plan has the right of subrogation and reimbursement, which means the Plan has the right to request a refund of payments made under the conditions described below.

The Plan will be subrogated to any claim you have against a third party and will have a right of reimbursement from the proceeds of any settlement, judgment or other payment you obtain from or on behalf of a third party, provided:

- You were injured, became ill or suffered a condition for which the third party is legally liable due to an act or omission, and

- Benefits were paid to you or on your behalf under the Plan for such injury, illness or condition.

If you recover against any third party legally responsible for the injury, illness or condition for which payment under this Plan was made, the Plan will be reimbursed out of the first funds of such recovery or settlement received by you or on your behalf, regardless of how those sums are characterized. The Plan's right of recovery will be a prior lien against any proceeds you recover, and this right may not be defeated or reduced by the application of any so-called "make-whole doctrine" or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

If you sue to recover your expenses, the Plan can join in the suit. If you do not sue, the Plan can do so in your name. You may not incur any expenses on behalf of the Plan, and no court costs or attorney's fees may be deducted from the Plan's recovery, unless the Plan, in its sole discretion, gives its prior express written consent. This right may not be defeated by a "common fund doctrine" or any other such doctrine.

You are obligated to avoid doing anything that would prejudice the Plan's right to subrogation and reimbursement and are obligated to execute any documents and to take any action to furnish information and assistance as is required by the Plan to enforce this right. If you refuse

or fail to reimburse the Plan as described above, the Plan may institute legal action against you to recover the benefits paid or, at its discretion, may withhold the amounts owed from payments for unrelated subsequent or previously existing claims.

CLAIMS PROCEDURE AND CLAIMS REVIEW PROCEDURE

Definitions

- "Death/AD&D Claim" means a claim for Death Benefits or Accidental Death and Dismemberment Benefits, other than a claim for continuance of Death Benefit Coverage during a period of Total Disability.

- "Denial" (or "Denied") means any denial, reduction or termination of, or failure to provide or make payment for, in whole or part, a claimed benefit under the Plan.

- "Disability Related Claim" means a claim for Temporary Disability Income Benefits or for continuance of Death Benefit coverage during a period of Total Disability.

- "Relevant" means, with respect to the relationship of a document, record or other information to a claim, that the document, record or information:

  (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 under the Plan; 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.

- "Post-Service Claim" means a claim for Dental Benefits or Vision Benefits.

Filing Requirements for Claims

In order to receive a benefit under the Plan, you must submit written notice of claim to the Plan within the period of time following the date of loss or the date the service or supply was furnished, as described in the following two paragraphs. Written notice of claim must be submitted to the Plan at the appropriate Field Office. Upon receipt of a written notice of claim, the Plan will furnish you with any forms that are required for filing proofs of loss.

For Dental, Vision and Temporary Disability Income Benefit claims, written proof of loss must be submitted to the Plan within a reasonable period of time, not to exceed 18 months following the date of loss or the date the service or supply was furnished. Claims submitted more than 18 months following the date of loss or the date the service or supply was furnished will not be considered for reimbursement.

For Death Benefit claims and Accidental Death and Dismemberment Benefit claims, written proof of loss must be submitted to the Plan within 90 days following the date of loss. Claims

will not be reduced or denied for failure to provide notice within 90 days, provided it was not reasonably possible to furnish notice and notice was furnished as soon as it was reasonably possible.

Below are additional filing requirements for each specific type of claim.

Death Benefit Claims

- Submit a certified copy of the death certificate to your Field Office.
- The Field Office will complete the death claim form and forward it to the Administrative Manager.
- The Administrative Manager will further process the claim and send it to the Company.

Death Benefit Claims With Assigned Benefits

- Submit a certified copy of the death certificate to the Field Office.
- Have all Beneficiaries complete and sign a Death Claim Assignment Form with the desired amount assigned and the assignee's name listed where indicated. The completed Death Claim Assignment Form should be returned to the appropriate Field Office.
- The Field Office will complete the death claim form and forward it to the Administrative Manager.
- The Administrative Manager will further process the claim and send it to the Company.

Accidental Death and Dismemberment Claims

- Obtain an application for "Accidental Dismemberment or Loss of Sight Benefit" form from the Field Office.
- You must complete and sign the "Statement by the Employee" section of the form. All questions must be answered in full.
- Have your attending Physician complete and sign the "Statement of the Attending Physician" section of the form. Be sure the Physician has given all the information requested. Some Physicians may choose to use their own Attending Physician's Statement. This is acceptable provided the information given is the same as that required on the form.
- Return the form(s) to your Field Office in order that they may complete the form and forward it to the Administrative Manager.
- The Administrative Manager will further process the claim and send it to the Company.

Waiver of Premium Due to Total and Permanent Disability

- Obtain an "Initial Proof – Total and Permanent Disability" form from the Field Office.
- Have your attending Physician complete and sign the "Attending Physician's Statement." Be sure the Physician has given all of the information requested.
- Complete and sign the "Claimant's Section." All questions must be answered in full.
- Return the form to the Field Office so they may complete the form and send it to the Company.

Temporary Disability Income Benefit Claims

- Obtain a "Claim Form" and have your Physician complete and sign the Physician's information section on the reverse. Be sure that he or she has given all the information requested. Some Physicians choose to use their own "Attending Physician's Statement." This is acceptable. However, you are still required to complete the Claimant's Section on the "Claim Form."
- Return the "Claim Form" to your Field Office. Your Field Office will complete the "Claim Form" and send it to the Fund Office.

Dental Claims

- Show your identification card to the dental provider and pay the appropriate deductible and copayments and the provider will send a completed claim form to your Field Office.
- Your Field Office will verify your eligibility and forward the claim to the Fund Office.

Vision Claims

- When using a Davis Vision network vision care provider, show your identification card to the provider and pay the appropriate copayments and the provider will do the rest. There is generally no need to file any claim forms when you use a network vision care provider.
- When using a non-network vision care provider, please follow the instructions on page 48.
- If a network vision care provider declines to provide services or supplies unless you pay the entire cost, you should submit the claim by following the instructions for submitting a non-network vision care claim.

NOTE: All claims other than Vision Claims must be submitted to your Field Office.

Authorized Representative

You have the right to appoint an authorized representative to act on your behalf for the purpose of filing claims and seeking review of denied claims. You must notify the Plan in advance, in writing, of the name, address and phone number of the authorized representative.

Initial Claims Determination

Death/AD&D Claims

The Plan will notify you of the initial determination within 90 days after the filing. If necessary due to matters beyond the Plan's control, this 90-day period may be extended one time for up to 90 days. In this case, the Plan will notify you before the end of the initial 90-day period of the circumstances requiring the extension and the date by which a decision will be made.

Post-Service Claims

The Plan will notify you of the initial determination within 30 days after the filing. If necessary due to matters beyond the Plan's control, this 30-day period may be extended one time for up to 15 days. In this case, the Plan will notify you before the end of the initial 30-day period of the circumstances requiring the extension and the date by which a decision will be made. If the 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. You must submit the required information to the Plan within 45 days from your receipt of the notice, unless the Plan gives you additional time to respond.

Disability Related Claims

The Plan will notify you of the initial determination within 45 days after filing. If necessary due to matters beyond the Plan's control, this 45-day period may be extended for up to 30 days. In this case, the Plan will notify you before the end of the initial 45-day period of the circumstances requiring the extension, the date by which a decision will be made, the standards on which entitlement to the benefit will be based, the unresolved issues that prevent a decision on the claim, and the additional information necessary to resolve those issues and the response deadline of at least 45 days from receipt of the notice. If, prior to the end of the first 30-day extension, the Plan determines that a further extension of time is needed due to matters beyond its control, the Plan may obtain a second 30-day extension. In this case, the Plan will notify you before the end of the first 30-day extension, in a form that satisfies the notice requirements applicable to the first extension.

For any extension required due to your failure to submit information necessary to decide the claim, the time period for making the determination will be suspended from the date of the notice of extension until the earlier of (i) the date on which your response is received by the Plan or (ii) the response deadline of at least 45 days.

Notice of Initial Claims Determination

If a claim is Denied, the Plan's notice of initial claim determination will include the following:

- Specific reason(s) for the Denial;
- Reference to the specific Plan provisions(s) on which the Denial is based;
- A description of any additional material or information necessary to perfect the claim and the reasons why it is necessary;
- A copy or explanation of the Plan's Claims Review Procedure and the claimant's right to seek review;
- A statement of the your right to bring a civil action under ERISA Section 502(a) if benefits are Denied after review;
- For all claims other than Death/AD&D claims, 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
- For all claims other than Death/AD&D Claims, 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 Plan to the claimant's medical circumstances, or a statement that it will be provided free of charge upon request.

Claims Review Procedure

Time Period for Filing Appeals

If a claim is initially Denied, you may appeal the determination and receive a full and fair review, as described below.

In order to appeal a Denial, you must file with the Plan a written request for review no later than the following: (i) within 60 days following receipt of a Denial for Death/AD&D Claims; and (ii) within 180 days following receipt of a Denial for Post-Service Claims and Disability Related Claims.

If you do not file a timely written request for review, the initial determination on your claim will be final.

Documentation for Appeals and Hearings

A request for review must include your name and address, the date of the Denial notice being appealed, and the reason(s) for disputing the Denial. You may also submit any pertinent documentary material not already furnished to the Plan, such as written comments, documents, records and other information relating to the claim. You may obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information Relevant to the claim, including the names of any medical or vocational experts whose advice

was obtained by the Plan in connection with the initial determination, without regard to whether it was relied upon.

You may request a hearing to present your claim on appeal; however, the Trustees will decide whether a hearing is granted. If a hearing is granted, you will be notified of the date and may be represented at the hearing by an authorized representative.

Review of the Appeal

The review on appeal will be impartial and will comply with the following requirements:

- No deference will be given to the initial determination;

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

- The review will be conducted by the Trustees, or such one or more individual Trustees designated by the Board of Trustees to consider and decide the appeal, provided that the individual(s) deciding the appeal did not make, and are not subordinates of the person(s) who made, the initial determination; and

- If the initial determination is based in whole or part on medical judgment, the reviewer 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.

Time Period for Decisions on Appeal

- The Plan's determination on review will be made no later than the first meeting of the Board of Trustees that immediately follows the filing of the request for review;

- If, however, the claim is filed within 30 days prior to such board meeting, the Trustees will have until their second meeting following the filing to make a determination on review; and

- If the Trustees require a further extension of time for processing due to special circumstances and notify you in writing, prior to the extension, of the special circumstances and the date by which a determination will be made, they will have until their third board meeting following such filing by which to make a determination on review.

- The Plan will notify you of the final determination on review as soon as possible but no later than five (5) days after it is made. For any extension of time required due to your failure to submit information necessary to decide the claim on review, the time period for making the benefit determination on review will be suspended from the date on which notification of the extension is sent to you, until the date you respond to the request for additional information. Nothing in this Claims Review Procedure precludes a voluntary extension of the response deadline if agreed to by both you and the Plan.

Content of Notice of Denial on Review

If the claim is Denied on review, the Plan's notice will include the following information:

- The specific reasons for the Denial;
- A reference to the specific Plan provisions on which the Denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information Relevant to the claim and a statement of your right to bring an action under ERISA Section 502(a);
- Any internal rule, guideline, protocol or other similar criterion that was relied upon in making the Denial or a statement that it was relied upon and that a copy will be provided free of charge upon request;
- If the Denial is based on medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that it will be provided free of charge upon request; and
- A statement describing any voluntary alternative dispute resolution options, such as mediation, that are available, and the claimant's right to obtain information about any such procedures.

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

Insured Benefits

The Death Benefit coverage and Accidental Death and Dismemberment Benefit coverage offered through the Plan are fully insured by an insurance company ("the Company") and are subject to the terms and conditions of the insurance policy in effect at the time of death/dismemberment. If there is a discrepancy between: (i) the above Claims Procedure and Claims Review Procedure applicable to claims for Death Benefits or Accidental Death and Dismemberment Benefits; and (ii) the actual claim procedures and claim review procedures of the group life insurance policy produced by the Company, the actual provisions of the Company's policy will prevail, provided the provisions of the Company's policy comply with the Employee Retirement Income Security Act of 1974 (ERISA).

Legal Action

You may not bring legal action to recover benefits under the Plan unless you or your authorized representative has first filed timely a written notice of claim, and fully complied with and exhausted all of the requirements of the Claims Procedure and Claims Review Procedure. In no event may you bring legal action for a claim involving the Death Benefit or the Accidental Death and Dismemberment Benefit later than three years after the time proof of claim is required. For

all other claims under the Plan, in no event may you bring legal action later than one year following a final determination of a claim under the Plan.

GENERAL PROVISIONS

Medical Examination

No medical examination is required for you or your Dependent to secure initial coverage. However, the Trustees have the right to require you or your Dependent to be examined by a Physician, Dentist or other licensed or certified health care provider of the Trustees' choosing as often as they may reasonably require during the pendency of the claim. The Trustees also have the right to have an autopsy performed, as permitted by law, in the case of death.

Right of Recovery

The Plan has the right to recover erroneous payments and excess payments, including payments that exceed the maximum amount of payment necessary to satisfy the coordination of benefits provisions. The Plan may recover such erroneous or excess payments from any person, provider or entity to or for or with respect to whom such payments were made, or from any insurance company or coordinating plan who should have made such payment under the coordination of benefits provisions. In addition, the Plan may offset such payments from other benefits payable under the Plan to or for the Participant for whom the erroneous or excess payment was made.

Assignment and Third Party Payment

The Plan will honor a written assignment of Dental and/or Vision Benefits to providers only, if received in acceptable form prior to payment. No other assignment of benefits will be valid.

Benefits payable under the Plan will not be subject in any manner 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.

Adjustments

The coverage and amount of benefits under the Plan are subject to adjustment according to the terms of the Plan. This includes any adjustment required by reason of a change in your status as an active or Retired Employee or the status of your eligible Dependent.

INFORMATION ABOUT THE PLAN

Plan Name and Trust Fund Name

The Plan is known as the New Orleans Employers – International Longshoremen's Association, AFL-CIO Welfare Plan Rules and Regulations and Plan Benefits. The Trust Fund through which the Plan's benefits are provided is known as the New Orleans Employers – International Longshoremen's Association, AFL-CIO Welfare Fund. It is a jointly administered trust fund, initially established effective October 1, 1956, by the Unions and certain Employers in the Port of New Orleans and Baton Rouge area, pursuant to a Collective Bargaining Agreement.

Type of Plan

This Plan is a group health plan maintained for the purpose of providing death benefits, accidental death and dismemberment benefits, temporary disability income benefits, vision benefits, and dental benefits.

Plan Sponsor

The Plan is sponsored and administered by a joint Board of Trustees consisting of Union representatives and Employer representatives. The address and telephone number that you may use to contact the Board of Trustees is:

New Orleans Employers – International Longshoremen's Association, AFL-CIO Welfare Plan
147 Carondelet Street, Suite 300
New Orleans, LA 70130
(504) 525-0309

Trustees of the Plan

Union Trustees

Mr. James McCleland, Jr. (Co-Chairman)
Vice-President, Assistant Business Agent
ILA Local 1497
2337 Tchoupitoulas Street
New Orleans, LA 70130

Mr. Dwayne Boudreaux
President
ILA Local 2036
2337 Tchoupitoulas Street
New Orleans, LA 70130

Mr. James Campbell
President
ILA Local 3000
P. O. Box 52766
New Orleans, LA 70152-2766

Mr. Mark Ellis
Secretary-Treasurer
ILA Local 3000
P. O. Box 52766
New Orleans, LA 70152-2766

Mr. Lloyd C. Irvin
President
ILA Local 3033
329 Allendale Drive
Port Allen, LA 70767

Employer Trustees

Mr. Sid Hotard, (Co-Chairman)
Manager, Administration
SSA Gulf, Inc.
3413 Jourdan Road
New Orleans, LA 70126

Mr. Nick Jumonville
President
Midgulf Association of Stevedores, Inc.
721 Richard Street, Suite A
New Orleans, LA 70130

Mr. Joseph R. Hightower
General Manager
CSA Equipment Corporation
3413 Jourdan Road
New Orleans, LA 70126

Mr. Jeffrey Hakala
Vice President
Ceres Gulf, Inc.
50 Napoleon Avenue
New Orleans, LA 70115

Mr. Keith Palmisano
Assistant Vice President, General Cargo Operations
Ports America
601 Louisiana Avenue
New Orleans, LA 70115

You may obtain a complete list of the individual Employers and Employee organizations participating in the Plan by written request to the Administrative Manager. You may examine the list at the Administrative Manager's office upon ten days' written notice. ERISA allows the Plan to charge a reasonable fee for the copying costs. You may want to ask the amount of the fee before requesting copies.

Plan Administration

The Plan is administered by the Board of Trustees, which can be contacted as follows:

Board of Trustees
The New Orleans Employers – International Longshoremen's Association, AFL-CIO, Welfare Plan
147 Carondelet Street, Suite 300
New Orleans, Louisiana 70130
(504) 525-0309

The Board of Trustees has the full and exclusive authority and discretion to determine all matters arising under the Plan, including but not limited to questions of eligibility, the amount of benefits payable, all methods of providing and arranging for benefits, and the interpretation and construction of the provisions of the Plan and Trust Agreement for the Fund. Any determination, interpretation or construction adopted by the Trustees is binding on all persons. No officer, agent or employee of the Union or Employer is authorized to speak for or on behalf of the Board on any matter relating to the Plan.

The Board of Trustees has delegated certain responsibilities for the Plan's day-to-day operations to an Administrative Manger. The Administrative Manager is:

Thomas R. Daniel
The New Orleans Employers – International Longshoremen's Association, AFL-CIO, Welfare Plan
147 Carondelet Street, Suite 300
New Orleans, Louisiana 70130
(504) 525-0309

Agent For Service Of Legal Process

The Board of Trustees has been designated as agent for service of legal process. Legal process may be served on the Board of Trustees or upon any member of the Board of Trustees at the address listed above.

Employer Identification Number (EIN) and Plan Number

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 72-0570875. The Plan Number assigned by the Board of Trustees to the Plan is 501.

Plan Year

The records of the Plan are kept on the basis of a fiscal year, which begins on October 1 and ends on the following September 30. For purposes of maintaining the Plan's fiscal records, the end of the Plan year is September 30. This fiscal year is also known as the "Plan Year."

Collective Bargaining Agreements

The Plan is maintained pursuant to various Collective Bargaining Agreements requiring the signatory Employers to make contributions to the Fund at fixed rates. You may examine these Collective Bargaining Agreements at the Administrative Manager's office upon ten days' advance written request. In addition, you may obtain copies of any such agreements, for a reasonable charge, upon written request to the Administrative Manager.

Contribution Source

Contributions to the Plan are made primarily by Employers in accordance with Collective Bargaining Agreements. The Collective Bargaining Agreements require contributions to the Plan at a fixed rate per hour. Employer Contributions for Employees of the Fund, Royalty Escrow Account, Union and International Union are made at the same fixed rate per hour but on the basis of 40 hours per week.

Employees and their Dependents are not allowed to contribute to the Plan except for the following circumstances for which continuation of coverage on a self-payment basis is permitted by the Plan: (1) surviving Dependent spouses age 50 or older at the time of a covered active Employee's death may self-pay to continue coverage; (2) eligible Employees and Dependents may self-pay to continue coverage under COBRA; and (3) eligible Employees who take a qualified military leave of absence exceeding 31 days may self-pay to continue Dental and Vision Benefits coverage under USERRA. In all such cases, the Board of Trustees will determine the amount of the required self-payments based upon the cost of providing the coverage and any additional amounts for related administrative costs permitted by law.

You may obtain, upon written request to the Administrative Manager, information as to whether a particular employer or employee organization participates in the Plan and, if so, their address.

Plan Assets

The Plan's assets and reserves are held in the custody of Whitney National Bank and invested by the Board of Trustees under an investment management contract.

Funding Medium

Benefits are provided from the Plan's assets, which are accumulated in the Fund pursuant to contributions made by contributing Employers and self-payments made by eligible participants to continue coverage when authorized by the Plan, as well as investment earnings related thereto. These assets are held by the Trustees in trust for the purpose of providing benefits to Participants and defraying reasonable administrative expenses of the Plan. The Plan's assets include any insurance policies purchased by the Trustees to provide Death Benefits and Accidental Death and Dismemberment Benefits under the Plan.

Insurance Company

The Plan's Death Benefits and Accidental Death and Dismemberment Benefits are provided under a group insurance policy issued to the Fund by:

Reliance Standard Life Insurance Company
6101 Carnegie Blvd., Suite 300
Charlotte, NC 28209
(800) 644-1103

Selection of Physicians and Facilities

The Plan pays benefits for certain health care expenses, but the Plan does not provide hospital or medical services. Accordingly, the Plan is not responsible for any acts or omissions by hospitals or other facilities, or by Physicians, other medical professionals, or any facility staff member or employee thereof.

Qualified Medical Child Support Orders

Upon written request to the Administrative Manager, you may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations.

Procedure for Obtaining Additional Plan Documents

If you wish to inspect or receive copies of additional documents relating to the Plan, you may contact the Administrative Manager at the address or phone number listed above. You may be charged a reasonable fee to cover the cost of any materials you wish to receive.

Amendment and Termination of the Plan

The Board of Trustees reserves the right, in its sole discretion, at any time and from time to time, to:

- Amend or terminate either the amount or condition with respect to the payment of any benefit, regardless of employment or retirement status, or illness, injury, condition or disability suffered prior to the effective date of amendment or termination; or
- Alter or postpone the method of payment of any benefit; or
- Amend or terminate the right to continue coverage on a self-payment basis; or
- Amend or terminate any other provisions of the Plan for any class of Employees, Retired Employees or Dependents.

In no event, however, may any amendment or termination cause any part of the Fund to revert to an Employer.

In the event of a Plan termination, only claims and expenses incurred prior to the termination date will be paid in accordance with the Plan. Payment will be made from the assets remaining in the Fund, including any insurance policies issued to the Fund, for the purpose of providing benefits. If there are not enough assets remaining to pay all outstanding claims, the Trustees will decide the manner in which the remaining assets will be used. In no event will the Board of

Trustees or any individual Trustee, Employer, Union or other individual or entity be liable to provide the payment of benefits over and beyond the Plan assets in the Fund available for such purpose.

NOTHING IN THIS BOOKLET IS MEANT TO INTERPRET OR CHANGE IN ANY WAY THE PROVISIONS EXPRESSED IN THE PLAN. THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THIS PLAN WHENEVER, IN THEIR SOLE DISCRETION, CONDITIONS SO WARRANT.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

This statement of your rights under ERISA is required by federal law and regulation.

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

Receive Information About Your Plan and Benefits

You have the right to:

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

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

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

Continue Group Health Plan Coverage

You have the right to:

- Continue health care coverage for yourself or your Dependent spouse or children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when: 1) you lose coverage under the Plan; 2) you become entitled to elect COBRA continuation coverage; 3) your COBRA continuation coverage ceases, if you request it before losing coverage; or 4) if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your 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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrative Manager to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Manager.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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 federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the Plan by following the Claims Procedure and Claims Review Procedure described in this booklet before you may file suit in any court. You will then have one year in which to start a lawsuit, as described on page 61. In no event may you bring legal action in a court later than this one-year period.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrative Manager. 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 Administrative Manager, you should: 1) contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or 2) call the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272); or 3) visit the EBSA website at www.dol.gov/ebsa; or 4) write to the EBSA's Office of Participant Assistance at the following address:

Office of Participant Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Suite N-5625
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272).

PRIVACY AND SECURITY RULES

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

Your PHI will not be used or disclosed by the Plan or Plan Sponsor 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 all of our business associates, such as the 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 other benefit or employee benefit plan of the Plan Sponsor. 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.

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 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.

If you have questions about the privacy or security of your health information or wish to file a complaint under HIPAA, please contact the Administrative Manager for the Plan at the Fund Office. The Administrative Manager also serves as the Plan's Privacy and Security Officer.

IMPORTANT

IT IS YOUR RESPONSIBILITY TO REPORT ANY CHANGE IN YOUR STATUS

It is important that you notify your Field Office when the following conditions arise:

- You change your home address.
- You wish to change your Beneficiary.
- You marry (you may need to change your name or you may desire to add your spouse as an eligible dependent by submitting a copy of the marriage certificate to your Field Office).
- You acquire a child through birth, adoption or placement for adoption.
- Your eligible dependent child ceases to qualify as your dependent (e.g., the child reaches age 21 or is a student who reaches age 23).
- You and your spouse divorce.

NEW ORLEANS EMPLOYERS – INTERNATIONAL LONGSHOREMEN'S ASSOCIATION, AFL-CIO WELFARE PLAN

ADMINISTRATIVE MANAGER'S OFFICE
147 Carondelet Street
Suite 300
New Orleans, Louisiana 70130

Thomas R. Daniel, Administrative Manager
(Administrative Manager's Office hours 9:00 A.M. to 5:00 P.M.)
(504) 525-0309

Field Office	Office Hours	I.L.A. Locals Serviced	Address & Phone Number
B	8:00 A.M. - 4:00 P.M.	1497, 2036 and Former Locals 1683, 1655 and 1802	2337 Tchoupitoulas St. New Orleans, LA 70130 581-3196, ext. 2
E	8:00 A.M. - 4:00 P.M.	3033 and Former Locals 1830 and 1833	329 Allendale Drive P.O. Box 197 Port Allen, LA 70767 225-344-5417
G	8:00 A.M. - 4:00 P.M.	3000 and Former Locals 854, 1418,1419, 1515 and 1683	ILA Local 3000 Trailer Napoleon Avenue Wharf 895-5779

For locations of Davis Vision network providers, call 1-800-999-5431.