MARITIME ASSOCIATION – I.L.A. WELFARE FUND

DENTAL SUPPLEMENT PLAN

October 1, 2014

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

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

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

THE BENEFITS IN THIS DENTAL SUPPLEMENT PLAN MAY BE DISCONTINUED AT ANY TIME AND ARE SUBJECT TO RENEWAL EACH YEAR AT THE DISCRETION OF THE TRUSTEES.

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DEFINITIONS FOR THE PURPOSE OF THIS PLAN

To help you more clearly understand the Dental Supplement Plan established in this booklet, some of the terms used in describing the plan as it applies to you and your eligible dependents, if any, are defined below.

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

ELIGIBLE PARTICIPANT CLASSES -

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

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

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

RETIREE COVERAGES –

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

Class 2 Retirees - Employees who (1) are eligible to receive a retirement benefit based on average yearly hours of at least 1,400 Credit Hours but less than 1,800 Credit Hours and (2) satisfy the requirements as set forth in the Maritime Association – I.L.A. Pension Plan for entitlement to a disability pension or satisfying the requirements set forth in the Maritime Association – I.L.A. Pension Plan for an age pension based on a minimum of twenty years of credited service (or continuous service if applicable in accordance with the requirements of the Maritime Association – I.L.A. Pension Plan), regardless of whether the Employee receives the retirement benefit from the Maritime Association – I.L.A. Pension Plan or the Maritime Association – I.L.A. Retirement Plan or both based on age or disability, and (3) who have qualified for Welfare Fund coverage as an Employee within the five years immediately preceding the effective retirement date or date of death.

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

the Maritime Association – I.L.A. Retirement Plan or both based on age or disability, and (3) who have qualified for Welfare Fund coverage as an Employee within the five years immediately preceding the effective retirement date or date of death.

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

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

GENERAL DEFINITIONS

Benefits Year – The twelve month period beginning January 1.

Course of Treatment – A planned program to correct a diagnosed dental problem or disease. A course of treatment starts when the Dentist or Physician first treats the dental problem.

Covered Dental Expenses – The items of expense for which Dental Expense Benefits may be paid are called Covered Dental Expenses. Covered Dental Expenses are show in Section III.

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

Dentist – A person who has a license to practice as a Dentist in the state where the service is performed.

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

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

Period of Orthodontic Treatment – The period begins on the date of the first orthodontic expenses incurred by the Employee for himself or a covered Dependent and continues for the length of time required by the Dentist or Physician to complete the proposed treatment and correction.

DEFINITIONS FOR THE PURPOSE OF THIS PLAN

Physician – A person who has a license to practice as a Physician or Surgeon in the state where the service is performed.

Proof of Claim – In order to determine the benefits payable under this Plan, diagnostic aids such as pre-operative x-rays and other support documents will likely be required. If these aids are not sent or are not available, then it may not be possible to provide a benefit for the claim or may receive a lesser benefit than would have been allowed if the required proof had been provided.

Usual and Customary Charge –For any service or supply, the Usual and Customary Charge will not exceed:

(1) the amount customarily charged by the provider for it; or
(2) the charge for the service or supply made by providers of comparable services or supplies in the same locality.

A special provision will apply when there are no providers of comparable services or supplies in the same locality, or in the event of an unusual type of service or supply. When this happens, the Trustees will decide whether the charge is appropriate, based on:

(a) the complexity involved;
(b) the degree of professional skill required;
(c) the cost of supplies; and
(d) other pertinent factors.

The Trustees may decline to pay flat rate charges when procedures, fees and/or time involved are not itemized.

The covered dental expense will be limited to the Usual and Customary Charge for the most economical service or material which meets broadly accepted standards of dental care.

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

COVERAGE FOR YOU – WHEN YOU ARE ELIGIBLE

Active Employees (Classes 1, 2, 3) – You are eligible for the benefits described on the following pages if you are an Employee of one or more Employers who are contributing to the Maritime Association – I.L.A. Welfare Fund, and you have earned at least 1,000 Credit Hours during the last Eligibility Year.

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

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

ELIGIBLE CLASSES AND CHANGES IN BENEFITS

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

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

INVOLUNTARY ACTIVE MILITARY SERVICE

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

NOTE: This continuation does not invalidate the war or act of war exclusion applicable to the Medical and Dental Benefits as shown in Section III.

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

COVERAGE FOR YOUR ELIGIBLE DEPENDENTS

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

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

- Your unmarried, children through age 19 (unless otherwise specified), which includes the following:
  - Natural born children of a legal marriage;
  - Adopted children, including children placed with you for the purpose of adoption;
  - Step-children through a legal marriage;
  - Any child declared to be your child by a certified court order (Order Establishing Parent Child Relationship, Acknowledgment of Paternity, or Qualified Medical Child Support Order).

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

If you and your spouse are covered under the Plan as Employees, either, or both may (a) be considered a Dependent for purposes of dental benefits; and (b) elect the dental benefits with respect to children eligible as defined above.

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

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

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

REPORTING CHANGES IN ELIGIBILITY OF DEPENDENTS

YOU SHOULD NOTIFY THE WELFARE FUND OFFICE WHEN YOU ACQUIRE A DEPENDENT. ALSO, YOU MUST NOTIFY THE WELFARE FUND OFFICE WHEN A DEPENDENT IS NO LONGER ELIGIBLE. YOU WILL BE RESPONSIBLE FOR ANY OVERPAYMENTS INCURRED DUE TO PAYMENTS MADE ON BEHALF OF INELIGIBLE DEPENDENTS. WITH RESPECT TO ANY OVERPAYMENT, THE AMOUNTS SHALL BE RECOVERABLE REGARDLESS OF WHETHER THE FUNDS

HAVE BEEN COMMINGLED WITH OTHER ASSETS AND THE PLAN MAY RECOVER FROM ANY AVAILABLE FUNDS, WITHOUT THE NEED TO TRACE THE SOURCE OF THE FUNDS AND WITHOUT REGARD TO THE SPECIFIC MONEY RECEIVED AS THE OVERPAYMENT.

WHEN COVERAGE ENDS

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

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

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

TERMINATED VESTED PARTICIPANTS

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

CONTINUATION FOR DISABLED EMPLOYEES

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

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

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

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

Credit Hours During Disability

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

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

If you qualified as a Class 3 Employee during the preceding Eligibility Year, you may receive for each day of such total disability or temporary partial disability, Credit Hours prorated on the basis of the preceding Eligibility Year's hours but only to the extent necessary to qualify you as a Class 3 Employee. If these additional Credit Hours granted during your total disability or temporary partial disability will not qualify you as a Class 3 Employee, this provision will then apply only to the extent necessary to qualify you as a Class 2 Employee or a Class 1 Employee, whichever the case may be.

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

Extending Coverage For Additional Year(s)

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

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

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

Summary

Disability Crediting – Continuation for Disabled Employees

- 36 Month Maximum Crediting
- Disability Credit added as follows:

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

CONTINUATION FOR DISABLED DEPENDENTS

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

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

CONTINUATION FOR DEPENDENTS OF DECEASED EMPLOYEES

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

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

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

(i) you are covered as a Retired Employee; or

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

(iii) you have a minimum of twenty years Credited Service at the time of your death.

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

SECTION II – SCHEDULE OF BENEFITS

SCHEDULE OF COMPREHENSIVE DENTAL SUPPLEMENTAL BENEFITS

The supplemental dental benefits described in this booklet are limited and provided in accordance with the Maintenance of Benefits provisions outlined on page 16.

Class 1 Employees and Eligible Dependents

Preventative Care	
Benefits equal to 100% of Covered Dental Expenses incurred	100%
All Other Dental Services	
Benefits equal to 80% of Covered Dental Expenses incurred	80%

Benefits Year Deductible – Preventative Care and All Other Dental Services	
First Benefits Year	$25.00
Per Benefits Year for the next 4 consecutive years of coverage	$10.00
After 5 consecutive years of coverage	NONE
Maximum Benefit	
For all covered dental care or treatment during each Benefits Year	$1,500.00

Benefits are payable for Covered Dental Expenses incurred, but shall not exceed the Maximum Benefit.

Class 2 Employees and Eligible Dependents

Preventative Care	
Benefits equal to 100% of Covered Dental Expenses incurred	100%
All Other Dental Services	
Benefits equal to 80% of Covered Dental Expenses incurred	80%

Benefits Year Deductible – Preventative Care and All Other Dental Services	
First Benefits Year	$25.00
Per Benefits Year for the next 4 consecutive years of coverage	$10.00
After 5 consecutive years of coverage	NONE
Maximum Benefit	
For all covered dental care or treatment during each Benefits Year	$2,000.00

Benefits are payable for Covered Dental Expenses incurred, but shall not exceed the Maximum Benefit.

Class 3 Employees and Eligible Dependents

Preventative Care	
Benefits equal to 100% of Covered Dental Expenses incurred	100%
All Other Dental Services	
Benefits equal to 80% of Covered Dental Expenses incurred	80%

Benefits Year Deductible – Preventative Care and All Other Dental Services	
First Benefits Year	$25.00
Per Benefits Year for the next 4 consecutive years of coverage	$10.00
After 5 consecutive years of coverage	NONE
Maximum Benefit	
For all covered dental care or treatment during each Benefits Year	$2,000.00

Benefits are payable for Covered Dental Expenses incurred, but shall not exceed the Maximum Benefit.

Retirees (Class 1, 2, and 3 Retirees) and Eligible Dependents

You and your eligible dependents will be eligible for Class 1, Class 2, or Class 3 dental benefits depending on the average yearly hours on which your pension benefit is based unless you are a Section 18 (Formerly I.L.A. Locals 1525 and 1581) Retiree or Eligible Dependent. Please refer to the applicable class of coverage.

Class 5 Retirees and Eligible Dependents

Preventative Care	
Benefits equal to 100% of Covered Dental Expenses incurred	100%
All Other Dental Services	
Benefits equal to 80% of Covered Dental Expenses incurred	80%

Benefits Year Deductible – Preventative Care and All Other Dental Services	
First Benefits Year	$25.00
Per Benefits Year for the next 4 consecutive years of coverage	$10.00
After 5 consecutive years of coverage	NONE
Maximum Benefit	
For all covered dental care or treatment during each Benefits Year	$1,000.00

Benefits are payable for Covered Dental Expenses incurred, but shall not exceed the Maximum Benefit.

SECTION III – COVERAGE PROVISIONS

COVERED COMPREHENSIVE DENTAL EXPENSE BENEFITS FOR YOU AND YOUR ELIGIBLE DEPENDENTS

Covered Dental Expenses are charges for the services and supplies shown below. The services or supplies must be both: (a) medically or dentally necessary; and (b) ordered or prescribed by a Dentist or Physician.

Charges will be covered only to the extent that they do not exceed the Usual and Customary Charges generally made in the same area under similar conditions.

The Covered Dental Expenses are:

Preventative Services

1. Oral examinations and routine cleaning of teeth, but not more than 2 per Benefits Year.
2. Fluoride treatments.
3. Dental X-rays, but not more than one set of full mouth x-rays (including bitewings) during any Benefits Year.
4. Application of Pit and Fissure Sealants.

All Other Dental Services

1. Extraction (removal) of teeth.
2. Oral surgery (cutting procedures in the mouth).
3. Filling of decayed or fractured teeth.
4. Anesthetics, when medically necessary and in connection with a covered dental procedure.
5. Periodontal treatment or surgery to remove diseased gum tissue or bone.
6. Endodontic treatment, including root canal therapy.
7. Antibiotic injection when given by the Dentist.
8. Repairs and recementing of crowns, inlays, bridgework or dentures.
9. Relining or rebasing of dentures.
10. Space maintainers for your Dependent children under age 19, to replace teeth prematurely removed or missing.
11. Emergency treatment to relieve pain.
12. Fixed bridgework, partial or full dentures, but only to replace teeth (excluding third molar) that are extracted after you or your Dependents are covered under this Plan. No benefits will be allowed for adjustments during the first 6 months after placement.
13. Add teeth to an existing fixed bridge, partial or full denture.
14. Replace an existing fixed bridge with a new bridge (See Limitations and Exclusions).
15. Replace an existing removable partial denture with a new partial. (See Limitations and Exclusions).
16. Replace an existing full denture with a new denture (See Limitations and Exclusions).
17. Crowns, inlays, onlays or gold fillings to restore teeth, but only when:
    (a) The tooth is fractured or has major decay; and
    (b) The tooth cannot be restored with fillings such as amalgam, plastic or composite resin.
18. Drugs and medicines dispensed by a licensed pharmacist under the written prescription of a Dentist for dental care.

19. Orthodontic treatment, if the initial active appliance is placed after coverage is in effect for the covered person.
20. Covered expenses will include examinations, x-rays, surgery, extractions, active appliances and adjustments of the appliances. Speech or myofunctional therapy and athletic mouth-guards are not covered expenses.
21. The Dentist must submit to the Fund Office a complete outline of the orthodontic problem, the proposed treatment, the charges for the treatment and the length of time for completion of the treatment.
22. Night Guards for Bruxism.
23. Dental Implants.

An expense is considered incurred on the date the service is rendered or the supply furnished, not always the date of billing. The service must be completed in order to be considered a Covered Dental Expense. Special conditions apply to Orthodontic Treatment and Extended Benefits.

Charges for dental services that are performed by (a) you or your spouse or (b) your or your spouse's parent, sister, brother or child are not covered.

Benefit Provision

Benefits will be paid for Covered Dental Expenses incurred by you or your Dependent as shown in the Schedule of Benefits. Covered Expenses will be subject to the Deductible as shown in the Schedule of Benefits in Section II. In no event will benefits paid to any covered person exceed the Maximum Benefit.

Deductible

The Deductible is the dollar amount of Covered Dental Expenses incurred by or on behalf of each person covered under the Plan once during each of the first five Benefits Years as shown in the Schedule of Benefits.

The Deductible applies separately to each covered person once each Benefits Year.

Any Covered Dental Expenses incurred during the last 3 months of the Benefits Year, which apply to the Deductible may also apply to the Deductible for the next Benefits Year. This is so you will not have to satisfy a deductible at the end of one year and at the start of another year.

Maximum Benefit

The Maximum Benefits is shown in the Schedule of Benefits. It applies separately to Covered Dental Expenses for each covered person. Any benefits paid on behalf of a covered person whether covered as an Employee or a Dependent will be combined for purposes of determining the Maximum Benefit.

Limitations and Exclusions

Benefits will not be paid for charges for:

(a) expenses incurred after the date coverage under the Plan ceases for you or your Dependents for any reason. This is true even though the expenses relate to a condition which began while you or your Dependent were covered. The only exception to this is described under the Extended Dental Benefits Provision;

(b) fixed bridgework or dentures to replace teeth that were missing prior to the date you or your Dependents became covered under this Plan, except that this exclusion shall cease to apply after you or a Dependent have been covered under this Plan for a period of two consecutive Benefits Years;

(c) treatment from anyone other than a Dentist or Physician (Routine cleaning of teeth and fluoride application when performed by a licensed dental hygienist under the direct supervision of, and billed by, the Dentist or Physician will be covered);

(d) facings, veneers or similar material placed on molar crowns or pontics (Teeth or spaces to rear of the second bicuspid);

(e) services or supplies that are partially or wholly cosmetic in nature, or directed toward a cosmetic end;

(f) any service or supply incurred, installed or delivered before you or your Dependent become eligible for benefits or after coverage terminates, except as shown under "Extended Dental Benefit Provision;"

(g) replacing a lost, missing or stolen prosthetic appliance;

(h) a broken appointment;

(i) any services received from a medical department, clinic or any facility provided or furnished by your or your Dependent's employer;

(j) any service that is not necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending Dentist;

(k) services or supplies that do not meet accepted standards of dental practice including experimental services or supplies;

(l) services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared;

(m) any duplicate prosthetic appliance except as specifically provided under Covered Expenses in Section III;

(n) claim form completion;

(o) oral hygiene or dietary instruction, or plaque control programs;

(p) wiring or bonding teeth or crowns to act as a splint for any reason;

(q) an injury arising from any employment or occupation;

(r) charges for full or partial dentures, if, during the five year period immediately preceding the date on which such charges are incurred, payment was made for 2 previous dentures or replacement of the same extracted teeth;

(s) charges for impacted teeth;

(t) an illness or injury covered by Workers' Compensation;

(u) services or supplies for which you are not required to pay;

(v) expenses incurred outside the United States, unless you or your Dependent are a resident and the charges are incurred while traveling on business or for pleasure;

(w) appliances or restorations to alter vertical dimension or restore occlusion;

(x) any service or supply which is covered in whole or in part by a plan provided, or sponsored, by the Policyholder; or

(y) services or supplies not specifically listed under Covered Dental Expenses in Section III."

Extended Dental Benefits Provision

If a covered person is incurring Covered Dental Expenses and this coverage ends, benefits will be considered as follows:

1. Charges for dentures will be considered if:
   a. the impression was made prior to the date coverage ends;
   b. the denture was ordered prior to the date coverage ends; and
   c. the denture is placed in the mouth within 90 days from the date coverage ends.

2. Charges for fixed bridgework, crowns and inlays will be considered if:
   a. the tooth or teeth were prepared prior to the date coverage ends;
   b. the impression was taken prior to the date coverage ends;
   c. the bridgework, crown or inlay was ordered prior to the date coverage ends; and
   d. the work is seated in the mouth within 90 days from the date coverage ends.

3. Charges for endodontic treatment, to include root canal therapy, will be considered if:
   a. the tooth was opened prior to the date coverage ends; and
   b. the procedure is completed within 90 days from the date coverage ends.

MAINTENANCE OF DENTAL BENEFITS WITH MILA

This Dental Supplement Plan provides supplemental benefits only on a maintenance of benefits basis as it relates to dental coverage provided under MILA. If you, your spouse or your eligible dependents also have coverage under a plan other than MILA, the Dental Supplement Plan will pay benefits as provided for herein only after all other group insurance plans have paid in accordance with the coordination of benefits provisions of the MILA plan and any other plan. This process prevents duplicate payments for the same dental expenses.

How Benefit Payments Work

Notwithstanding anything to the contrary in the Welfare Plan, all dental benefits provided for in this Dental Supplement Plan are subject to the following provisions.

The Welfare Plan will reduce its normal benefit by the benefit amount paid by the dental coverage provided through MILA (currently insured through Aetna) (the "Primary Plan"). As such, the dental benefits payable under this Welfare Plan shall be reduced to the lesser of (1) what it would have paid had the Welfare Plan been primary or (2) what it would have paid less the Primary Plan's payment.

If the Primary Plan benefit is…	Then…
Equal to or more than the Welfare Plan's benefit,	The Welfare Plan will not pay a benefit.
Less than the Welfare Plan's benefit,	The Welfare Plan will pay the difference between the Primary Plan's benefit and the Welfare Plan's benefit.

Benefits are calculated separately for each provider without regard to the liability of the Primary Plan. Once the normal plan liability is calculated, the Primary Plan's liability for the same service is subtracted from the Welfare Plan liability. No benefit credits are established. In no event will the Welfare Plan's payment for covered services together with the payment made by the Primary Plan exceed the amount that would have been payable if the Welfare Plan had been the primary carrier.

If You Are Overpaid Benefits

If by chance the Dental Supplement Plan makes benefit payments on allowable expenses that are more than 100% of the maximum benefit amount, the Welfare Fund reserves the right to recover the amount of the overpayment from individuals, insurance companies or any other Claim Administrators. If certain overpayments are not returned within four weeks of receipt, the Welfare Fund has the right to cancel your coverage and begin legal action to recover the overpayment.

SECTION IV – CLAIMS PAYMENT AND PROCEDURES

CLAIM PAYMENT AND PROCEDURES

All benefits payable on your behalf will be paid to you, if living, otherwise to the provider of service, recognized beneficiary, or if none, to your estate. The Trustees will be discharged of their obligations to the extent any such payment made in good faith.

How to File A Claim

Claims for benefits should be filed as soon as reasonably possible in order that timely payment may be made. Claims must be filed within ninety (90) days following the date the claim was incurred in order to be eligible for consideration for payment under the Plan. Failure to file claims within the time required shall not invalidate or reduce any claim if it can be demonstrated that it was not reasonably possible to file the claim within such time.

When you file a claim under the Dental Supplement Plan, you must submit proof of loss by providing the following documents:

- Explanation of Benefits from Aetna (or other dental insurance carrier if applicable)

You must send such documents to the Funds Office, either by mail, fax, or in person:

11550 Fuqua Street, Suite 425
Houston, TX 77034
281-484-7043 (fax) or 281-652-9068 (fax)

If you wish for the Welfare Fund Office to pay the dental expense benefits directly to the dentist, please simply note directly on the Explanation of Benefits form from Aetna to "pay dentist directly" and sign and date the form before submitting to our office.

Claim Appeal Procedures

Claims for benefits under the Plan are to be submitted to the Fund Office as provided above. Payment of claims under the Plan will be made through the Fund Office. If your claim for benefits under the Plan is denied, you will receive a written explanation giving detailed reasons for the denial, specific reference to policy provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, as well as an explanation of the Plan's claim appeal procedure.

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

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

Appeals should be made to the address indicated on the notice you receive from the Claim Processor.

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

- It was relied upon by the Claim Processor in making the decision;
- It was submitted, considered or generated (regardless of whether it was relied upon);
- It demonstrates compliance with the Claim Processor's administrative process for ensuring consistent decision-making; or
- It constitutes a statement of Plan policy regarding the denied treatment or service.

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

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

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

Notice of Decision on Review After Appeal

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

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review; and
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

Limitation on when a Lawsuit May Begin

You may not file a lawsuit to obtain benefits under the Plan until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

The law permits you to pursue your remedies under Section 502(a) of ERISA without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than two (2) years after the end of the year in which services were provided.

SECTION V – GOVERNING LAWS

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

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

- Examine, without charge, at the Fund Office, all documents governing the Plan, including the Plan, insurance contracts (if any), vendor contracts, and a copy of the latest annual report (Form 5500 series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including the Plan, insurance contracts (if any), vendor contracts, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each participant with a copy of this summary annual report.

You are entitled to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. You should review this Plan book for the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the material. This does not apply if the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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

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

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

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

If you elect to continue such coverage during such leave:

a) any required contributions must be paid to the Funds;
b) any change in benefits that occurs during the period of continuation will apply on the effective date of the change; and
c) the continuation during a military leave will run concurrently with a continuation during any other leave of absence.

Coverage may be continued until the earlier of:

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

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

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

You will continue to be covered in this Dental Supplement Plan until the end of the calendar year following the end of the contract year in which you returned. For purposes of qualifying for coverage in the next calendar year, you will be credited with hours prior to your return at the per year rate of the minimum hours necessary to be at the class level that you were at prior to your leave, and pro rata for a partial year.

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

SECTION V – GOVERNING LAWS

FAMILY MEDICAL LEAVE ACT OF 1993

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

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

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

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

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

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

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

SECTION VI – ADMINISTRATIVE INFORMATION

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

MARITIME ASSOCIATION - I.L.A.
PENSION, RETIREMENT, WELFARE AND VACATION FUNDS
TELEPHONE 281-484-4343
FAX 281-484-7043
11550 FUQUA ST., SUITE 425
HOUSTON, TEXAS 77034-4306

MARITIME ASSOCIATION – I.L.A. DENTAL SUPPLEMENT PLAN

RESOLVED, that the Amendment to the Maritime Association - I.L.A. Dental Supplement Plan, a copy of which is attached and is directed to be marked for identification and filed with the records of the Board of Trustees, be and the same hereby is approved and adopted.

IN WITNESS WHEREOF, the undersigned have executed this resolution on this 12th day of November, 2014.

BOARD OF TRUSTEES

MARITIME ASSOCIATION – I.L.A.
WELFARE FUND

Chelsea Egmon, Chairperson

Michael W. Dickens, Secretary-Treasurer

MARITIME ASSOCIATION - I.L.A.
PENSION, RETIREMENT, WELFARE AND VACATION FUNDS
TELEPHONE 281-484-4343
FAX 281-484-7043
11550 FUQUA ST., SUITE 425
HOUSTON, TEXAS 77034-4306

AMENDMENT TO THE MARITIME ASSOCIATION – I.L.A. DENTAL SUPPLEMENT PLAN

The Trustees of the "Agreement of Trust for the Maritime Association – I.L.A. Welfare and Vacation Funds," executed on April 28, 1994, and as subsequently amended, desire to amend the Maritime Association – I.L.A. Dental Supplement Plan (the "Plan"), effective as of November 1, 2014, as follows:

1. The following changes shall be added to the Definitions section of the Plan with respect to Retiree Coverages:

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

2. As amended hereby, the Plan is specifically ratified and reaffirmed.