SUMMARY PLAN DESCRIPTION
FOR
MARITIME ASSOCIATION – I.L.A.
RETIREMENT PLAN

January 1, 2021

Note: THIS BOOKLET MERELY SUMMARIZES KEY PLAN FEATURES AND DOES NOT REPLACE THE LEGAL PLAN DOCUMENT WHICH GOVERNS IN CASE OF ANY DIFFERENCES.

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SUMMARY PLAN DESCRIPTION

The summary of the Maritime Association – I.L.A. Retirement Plan contained in this booklet is meant to assist covered employees and other interested persons in understanding the benefits for participants, spouses, or beneficiaries and how those benefits are accrued and paid. The summary is not a complete description of the plan. A number of details have been described in a simplified manner. If there is any conflict between the summary and the formal plan document, the provisions of the formal plan document will control.

Subject to special statutory rules regarding qualified plan amendments, the Plan Trustees reserve the right to further amend the plan at any time.

1. WHAT IS THE PLAN AND WHAT IS ITS PURPOSE?

The Maritime Association – I.L.A. Retirement Plan (the "Plan") is an individual account defined contribution plan established and maintained under collective bargaining agreements between the South Atlantic & Gulf Coast District of the International Longshoremen's Association, and certain of its local unions (the "Union") and certain employers of longshoremen ("Employers"). The Plan, adopted as of October 1, 1996, is designed to provide retirement benefits for "Eligible Employees" (see Question 2) and give them the opportunity to save for their retirement. Plan benefits are funded by contributions made under collective bargaining agreements by Employers to Eligible Employees' Accounts (see Question 7) and any elective deferrals made by an Eligible Employee (see Question 5).

The Plan is administered by a Board of Trustees (the "Trustees"). Day-to-day administration of the Plan is handled by a professional staff employed by the Trustees. Plan Assets are held in a Trust Fund under the Agreement of Trust for Maritime Association – I.L.A. Retirement Fund (the "Trust Agreement"). The Plan operates on a "Plan Year" consisting of the 12 consecutive month period commencing on October 1 of each year (although the exact dates may change to stay in line with the payroll months established by the West Gulf Maritime Association). In addition, the Trustees contract with a designated record keeper, currently Vanguard, for the Plan and to provide the investment platform for the individual accounts of each Member of the Plan. If you would like to contact Vanguard directly with any questions regarding your account, you can reach them at 800-523-1188 or online at vanguard.com/retirementplans.

2. AM I ELIGIBLE TO BECOME A MEMBER OF THE PLAN?

You are eligible to become a Member of the Plan (an "Eligible Employee") if you are employed by Employers and you are:

- an employee of a signatory employer whose wage rates are established by collective bargaining agreements between the signatory unions and the West Gulf Maritime Association; or

- a walking foreman of the Employer; such term shall include an Employee who is a "general walking foreman" as that term is defined and used by a collective bargaining agreement between the Union and the West Gulf Maritime Association or equivalent agreement; or

- a diesel mechanic, electrician or crane maintenance employee utilized by a signatory employer to maintain waterfront equipment; or

- a gearman, mechanic or mobile crane operator of a signatory employer whose work involves waterfront equipment and/or operations; or

- utilized by a signatory employer to perform deep sea lines handling, portering and/or vessel's stores handling involving passenger and/or cruise vessels covered under a Memoranda of Understanding between the signatory unions and the West Gulf Maritime Association; or

- utilized by a signatory employer to perform general vessel deep sea mooring covered under a Memoranda of Understanding between the signatory unions and the West Gulf Maritime Association; or

- utilized by a signatory employer to perform non-dockside refrigerated cargo operations, waterfront crating and/or packaging work or bagging and/or packaging and/or distribution work or multi-purpose off dock warehousing work; or

- a regular, compensated, bona fide representative or employee of any local union who is a bona fide resident of the area between Lake Charles, Louisiana and Brownsville, Texas, or bona fide representative or employee of the South Atlantic & Gulf Coast District, I.L.A. or of the International Longshoremen's Association, AFL-CIO who is primarily headquartered or assigned to the South Atlantic & Gulf Coast District, I.L.A., including part-time employees of a local union, the District or the International receiving a prevailing wage from the labor organization for actual hours worked; or

- employed through any local union affiliated with the Union in the area from Lake Charles, Louisiana, to Brownsville, Texas, by an Employer who is a government entity prohibited by law from entering into a collective bargaining agreement with a union to the extent that such Employer voluntarily makes contributions to the Plan on the same basis and in the same amount as provided for by the equivalent West Gulf Agreement.

You are not an Eligible Employee and are not eligible to become a Member of the Plan if you are:

- an employee whose terms and conditions of employment are governed by a collective bargaining agreement which provides for "welfare only" benefit coverage;
- a nonresident alien who receives no earned income from an Employer that constitutes income from sources within the United States;
- an employee who is a leased employee; or
- an individual who is designated, compensated, or otherwise classified or treated as an independent contractor.

3. WHEN DO I BECOME A MEMBER OF THE PLAN?

If you are an Eligible Employee and you were a "participant" of the Maritime Association – I.L.A. Pension Plan (the "Pension Plan") on September 30, 1996, you automatically become a Member of this Plan as of October 1, 1996. Please note that this Plan is completely separate from the Pension Plan.

Otherwise, if you are an Eligible Employee, you become a Member as of the earlier of (a) the date as of which you first became an Eligible Employee in the first Plan Year in which you are credited with 1,000 or more Hours of Service (see Question 4), or (b) the first day of the Plan Year in which occurs the last day of the first 12-consecutive month period, beginning with the date you are first credited with an Hour of Service, during which you are credited with 1,000 or more Hours of Service. If you completed the Hours of Service requirement but you did not become a Member because you were not an Eligible Employee, you become a Member immediately upon becoming an Eligible Employee because of a change in your employment status. Once you meet the eligibility requirements to become a Member of the Plan, you do not need to meet such requirements again.

4. WHAT IS AN "HOUR OF SERVICE"?

An Hour of Service is any hour for which you are directly or indirectly paid, or entitled to payment, by Employers for the performance of duties, or for reasons other than the performance of duties, such as paid leaves in accordance with governing collective bargaining agreements. If applicable, such Hours of Service are credited to you for the computation period in which such duties are performed or in which occurred the period during which no duties were performed. However, no Hour of Service credit is given for any post-Normal Retirement Date period during which your sole payment is Worker's Compensation benefits under either federal or state compensation laws. An Hour of Service also includes each hour not credited above for which back pay is awarded by Employers. Hours of

Service with a member of a controlled group of employers (as defined in the Internal Revenue Code) with an Employer counts as Hours of Service with such Employer. A "Credit Hour," which is an hour for which you are paid as an Eligible Employee or for which you receive credit under the terms of the Plan for military service (limited to 1,000 hours per year), sickness or injury incurred off the job (limited to 400 hours per year), injury incurred on the job (limited to 400 hours per year), or for wartime conditions or catastrophes (limited to 1,000 hours per year), whether paid or unpaid, also counts as an Hour of Service.

5. HOW MUCH CAN I CONTRIBUTE TO THE PLAN?

As a participant under the Plan, you may elect to reduce your compensation by a specific percentage and have that amount contributed to the Plan. The Plan refers to this as an "elective deferral." There are two types of elective deferrals, pre-tax and Roth deferrals. For purposes of this Summary "deferrals" or "elective deferrals" generally mean both pre-tax deferrals and Roth deferrals. You may contribute to the Plan as elective deferrals up to 85% of your wages and capped at an annual amount set by the IRS ($19,500 for 2021). If you are age 50 or over, you may be able to make additional tax-deferred "catch-up" contributions ($6,500 for 2021). Only Members of the Plan may make elective deferrals.

If you make pre-tax deferrals, your taxable income is reduced by the deferral contributions, so you pay less in federal income taxes. Later, when the Plan distributes the deferrals and earnings, you will pay the taxes on those deferrals and the earnings. Federal income taxes on the pre-tax deferral contributions and on the earnings are only postponed.

If you elect to make Roth deferrals, the deferrals are subject to federal income taxes in the year of deferral. However, the Roth deferrals and, if you meet certain conditions, the earnings on the Roth deferrals are not subject to federal income taxes when distributed to you. This means that the earnings on the Roth deferrals may never be subject to Federal income tax.

Both your pre-tax and Roth deferrals will be subject to Social Security taxes at the time of your deferral.

Note that if you are considered a "highly compensated employee" as defined by the IRS, then the amount that you can contribute may be less than the maximum amount as established by the IRS depending on the Plan's needs with respect to satisfying the actual deferral percentage ("ADP") test. The details of the ADP testing are beyond the scope of this Summary Plan Description. If you think the limitations applied to such highly compensated employees may apply to you, please contact the Plan Administrator for more information.

6. MAY I MAKE A ROLLOVER CONTRIBUTION OR TRANSFER TO THE PLAN?

Yes, if you have an account balance in another qualified retirement plan or an IRA, you may move those amounts into this Plan, without incurring any tax liability, by means of a "rollover" contribution. Permissible rollovers also include designated Roth rollovers. You are always 100% vested in any amounts you contribute to the Plan as a rollover from another qualified plan or IRA. This means that you will always be entitled to all amounts in your rollover account. Rollover contributions will be affected by any investment gains or losses under the Plan.

You may accomplish a rollover in one of two ways. You may ask your prior plan administrator to directly rollover to this Plan all or a portion of any amount which you are entitled to receive as a distribution from your prior plan. Alternatively, if you receive a distribution from your prior plan, you may elect to deposit into this plan any amount eligible for rollover within 60 days of your receipt of the distribution. Any rollover to the Plan will be credited to your Rollover Contribution Account. You will be able to withdraw the amounts in your rollover account at any time.

Generally, the Plan will accept a rollover contribution from another qualified retirement plan or IRA. The Plan may have separate procedures limiting the type of rollover contributions it will accept. For example, the Plan restricts the acceptance of rollover contributions only if you are currently a participant in the Plan. In no event will these procedures be applied in a discriminatory manner. If you have questions about whether you can rollover a prior plan distribution, please contact the Plan Administrator for more information.

7. HOW MUCH DO EMPLOYERS CONTRIBUTE TO THE PLAN?

For each Plan Year, each Employer contributes as its contributions for such Plan Year an amount based upon its Eligible Employees' classifications as "Special," "New Entry," "Basic" or "Regular." Eligible Employees are classified as Special if their terms and conditions of employment are governed by a collective bargaining agreement that provides for a contribution crediting rate different from the New Entry, Basic or Regular contribution crediting rate. Eligible Employees are classified as New Entry if they (a) have not worked under Union or West Gulf Maritime Association contracts prior to December 1, 1990, and are not considered "previously employed" under such contracts, or (b) have worked prior to December 1, 1990, have not worked 2,000 or more hours between December 1, 1990 and September 30, 1996, and are not considered "previously employed" under Union or West Gulf Maritime Association contracts respecting the Port of Houston. Eligible Employees are classified as Basic if their terms and conditions of employment are governed by a collective bargaining agreement that provides for a $1.00 contribution crediting rate. If Eligible Employees are not Special, New

Entry or Basic, they are classified as Regular. Employer contributions are made without regard to current or accumulated profits of such Employers. The amount contributed by each Employer for each Plan Year is based upon the Retirement Plan Contribution Crediting Rates for the Plan Year. Such crediting rates are currently $1.00 for Special, $2.00 for New Entry, $2.00 for Basic (base $1.00 for Basic with an Additional Basic contribution of $1.00) and $4.00 for Regular for both Fully Automated and Non-Fully Automated Cargo. Contribution Hours are determined from reports submitted by the Employers, either directly or through the West Gulf Maritime Association Centralized Payroll System, to the Administrative Office of the Trust.

Employer contributions are credited to a "Special Contribution Pool" for the Plan Year for each Contribution Hour respecting each specified contribution crediting rate attributable to such Employer for each Special Member (who does not have a Benefit Payment Date (see Question 14) in such Plan Year). Employer contributions are credited to a "New Entry and Basic Contribution Pool" for such Plan Year for each Contribution Hour attributable to such Employer for each New Entry or Basic Member (who does not have a Benefit Payment Date in such Plan Year). Employer contributions are credited to a "Regular Contribution Pool" for the Plan Year for each Contribution Hour attributable to such Employer for each Regular Member (who does not have a Benefit Payment Date in such Plan Year).

Employer contributions for a Plan Year attributable to Members who have a Benefit Payment Date in such Plan Year are allocated for payment of Plan benefits (see Question 13) as of such Benefit Payment Date.

In addition, USMX Supplemental Contributions and Additional Employer Supplemental Contributions may be made to the Plan, the historical contributions for which are set forth in Appendix B to the Plan Document. Such additional contributions shall be allocated, for each Contribution Hour for each Eligible Employee, in the same manner as the otherwise scheduled Employer contributions for each such Eligible Employee. Note that these contributions are approved at the discretion of the Trustees and not guaranteed for each year.

8. IS AN ACCOUNT MAINTAINED FOR ME UNDER THE PLAN?

An "Account" is maintained for you under the Plan to which is credited your allocation of Employer contributions and forfeitures (see Question 13), pre-tax elective deferrals made pursuant to your election, if any, and Roth deferrals, in any (Question 5), rollover contributions and Roth rollover contributions (Question 6) and which is adjusted to reflect investment results (plus or minus) that your account earns (see Question 9).

9. HOW AND WHEN DOES MY ACCOUNT INCREASE?

Your Account increases through your share of allocations of contributions made by Employers under collective bargaining agreements (see Question 7), through your share of forfeitures (see Question 13), through your share of any allocations of net income from or increases in value of the Trust Fund investments (see Question 10), through elective deferrals made pursuant to your election, if any (see Question 5) and rollover contributions, if any (Question 6).

As of the end of each Plan Year, a portion of each Special Contribution Pool for that Plan Year is allocated to your Account if during any portion of that Plan Year you are classified as a Special Member with the specified contribution crediting rate attributable to such Special Contribution Pool. Your allocation is made on the basis of the Contribution Hours of all such Members, and your Account receives that portion of the Special Contribution Pool which your Contribution Hours represent as a percentage of all such Special Contribution Hours for the Plan Year. Multiple Special Contribution Pools with different contribution crediting rates may be established by the Trustees.

As of the end of each Plan Year, a portion of the New Entry and Basic Contribution Pool for that Plan Year is allocated to your Account if during any portion of that Plan Year you are classified as a New Entry or Basic Member. Your allocation is made on the basis of the Contribution Hours of all such Members, and your Account receives that portion of the New Entry and Basic Contribution Pool which your Contribution Hours represent as a percentage of all such New Entry or Basic Members' Contribution Hours for that Plan Year.

As of the end of each Plan Year, a portion of the Regular Contribution Pool for that Plan Year is allocated to your Account if during any portion of that Plan Year you are classified as a Regular Member. Your allocation is made on the basis of the Contribution Hours of all such Members, and your Account receives that portion of the Regular Contribution Pool which your Contribution Hours for the Plan Year represent as a percentage of all such Regular Members' Contribution Hours for that Plan Year.

As of the last day of each Plan Year, amounts contributed for Eligible Employees who do not become Members during that Plan Year and amounts forfeited under any provision of the Plan during that Plan Year, in excess of expenses applied against such forfeitures in the Trustees' discretion, are allocated to the Accounts of all individuals who were Members during any portion of that Plan Year. Your allocation is made on the basis of the Contribution Hours of all Members, and your Account receives that portion of the forfeitures which your Contribution Hours for the Plan Year represent as a percentage of all such Members' Contribution Hours for that Plan Year.

The value of your Account reflects the daily pricing of the assets in which your Account is invested (see Question 10) from the time of receipt by the Trustees until time of distribution.

10. HOW IS MY ACCOUNT INVESTED?

From time to time, the Trustees will make different Investment Funds available in which Trust Funds may be invested. You may designate the manner in which amounts allocated to your Account are invested among the Investment Funds. You may designate the investment of amounts allocated to your Account to one or more of the Investment Funds. You may also change your investment designation for future amounts to be allocated to your Account or convert amounts already allocated to your Account among Investment Funds. You may only make such designations or conversions according to the incremental amounts or frequency prescribed by the Trustees. If you fail to make a designation, the Trustees will invest contributions made to your Account in one or more Investment Funds designated by the Trustees. The Trustees encourage you to review your Account's investment designation from time to time.

11. MAY I MAKE WITHDRAWALS WHILE I REMAIN EMPLOYED?

The types of situations in which distributions can be made are governed by federal tax regulations. You may not withdraw any amount from the portion of your Account attributable to contributions made by the Employers prior to being entitled to retirement, disability, death or severance benefits (see Question 13).

Hardship Withdrawals

However, with respect to any portion of your Account attributable to elective deferrals (Question 5) only, you may be able to request a withdrawal of some or that entire portion if you satisfy certain requirements. Such a withdrawal is otherwise known as a "hardship withdrawal" and is limited to the following circumstances:

- Medical expenses described in section 213(d) of the Code previously incurred by the Member, the Member's spouse, or any dependents of the Member (as defined in section 152 of the Code); or necessary for any of these persons to obtain medical care described in section 213(d) of the Code, if the recipient is the primary beneficiary under the Plan;

- Purchase (excluding mortgage payments) of a principal residence for the Member;

- Payment of tuition, room and board and related educational fees for the next 12 months of post-secondary education for the Member, his spouse, children, dependent, or primary beneficiary under the Plan;

- The need to prevent eviction of the Member from his principal residence or foreclosure on the mortgage of the Member's principal residence;

- Payments for burial or funeral expenses of the Member's deceased parent, spouse, children, dependents, or primary beneficiary under the Plan;

- Expenses for the repair of damage to the Member's principal residence that would qualify for the casualty deduction under section 165 of the Code (determined without regard to whether the loss exceeds 10% of adjusted gross income); and

- Expenses and losses (including loss of income) incurred by the Member on account of a disaster declared by the Federal Emergency Management Agency (FEMA) under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 100-707, provided that the Member's principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster.

The amount available as a hardship withdrawal is only that amount needed to satisfy the specific financial need and can include any amounts reasonably anticipated to be necessary to pay federal, state or local income taxes and penalties incurred as a result of the distribution, but only up to the amount of elective deferrals in your Account. Further, you must first obtain all distributions, other than hardship distributions, currently available under the Plan.

To make a hardship withdrawal, you will need to submit a written request along with any supporting documents needed to verify the financial need. You can obtain more information on the form to be completed and other required documents by contacting the Fund Office. If you are eligible to receive a hardship withdrawal from the Plan, the amount of the distribution will be paid as a lump sum as soon as possible after the Plan Administrator determines that you are eligible for such distribution. Please note that there are taxes and potentially penalties associated with receiving a hardship withdrawal. You should consult a tax advisor prior to requesting a hardship withdrawal.

Other In-Service Withdrawals

Aside from hardship withdrawals, if you have attained the age of 59½, you may elect, in writing, to withdraw from your Account an amount up to the balance of your elective deferrals, but no less than $200.

In addition, you may request a withdrawal from any rollover contributions at any time.

12. MAY I BORROW FROM THE PLAN?

The Plan does not provide for loans.

13. WHAT BENEFITS DO I RECEIVE UNDER THE PLAN?

Retirement Benefits: Your "Normal Retirement Date" is the earlier of the date you (a) complete 30 years of "Credited Service" (as defined below), (b) reach age 55 and complete 25 years of Credited Service, or (c) reach age 65 and the earlier of the date you have three years of Vesting Service or reach the fifth anniversary of the date you became a Member of the Plan. You will be deemed to have retired upon application to the Trustees upon retirement from the industry. If you retire on or after your Normal Retirement Date, you are entitled to a retirement benefit equal to the value of your Account on your "Benefit Payment Date" (see Question 14). Any contribution or forfeiture allocable to your Account after your Benefit Payment Date will be distributed as soon as administratively feasible. Your "Credited Service" equals your "credited service" under the Pension Plan, as of September 30, 1996, plus the number of Plan Years within your period of "Continuous Service" after October 1, 1996, in which you are credited with at least 1,000 Credit Hours. Your "Continuous Service" is the period beginning October 1, 1996, if you had "continuous service" under the Pension Plan as of September 30, 1996, or otherwise beginning with the first Plan Year beginning on or after October 1, 1996, in which you are credited with at least 400 Credit Hours, and ending with the Plan Year in which you die, become totally and permanently disabled, reach your Normal Retirement Date, or incur a "Break-in-Service." You incur a Break-in-Service if during a period of three consecutive Plan Years you are credited with less than 400 Credit Hours for each Plan Year during that period. Such a Break-in-Service is effective as of the last day of the second Plan Year during such three-consecutive Plan Year period.

Disability Benefits: If you become totally and permanently disabled, as determined by the Trustees under the Plan, you are entitled to a disability payment equal to the amount in your Account on your Benefit Payment Date. Any contribution or forfeiture allocable to your Account after your Benefit Payment Date will be distributed as soon as administratively feasible. You are considered totally and permanently disabled if so determined by the Trustees. You must submit to the Trustees evidence that you have applied for disability benefits under either the Federal Social Security Act or the Railroad Retirement Act and such other evidence and information as the Trustees may reasonably require to substantiate the existence of total and permanent disability. If requested by the Trustees, you must submit to an examination by any physician or physicians selected by the Trustees. The cost of any medical examination required by the Trustees is paid from the Trust. Neither the fact that you are receiving total and permanent disability benefits under the Federal Social Security Act or the Railroad Retirement Act, nor the fact that you have been denied such benefits by

the agency involved, is binding on the Trustees in their final determination of your total and permanent disability for purposes of the Plan. The action of the administering agency and such information as can be supplied by it in any given case is to be presented to the Trustees at their request for such weight as the Trustees wish to accord it, but neither the granting of disability benefits by the agency, nor its refusal to grant them, forecloses the Trustees from making their own determination of your total and permanent disability. You are not considered totally and permanently disabled for purposes of the Plan, however, if (a) you are engaged in any activity for gain or profit, unless engaging in such activity is not inconsistent with your disability status as determined by the Trustees in the exercise of their reasonable discretion or (b) if the Trustees, in the exercise of their reasonable discretion, determine that your total and permanent disability is due to criminal activity, addiction to narcotics, or military service.

Death Benefits: If you die, your beneficiary (see Question 15) is entitled to a death benefit equal to the amount in your Account as of your Benefit Payment Date. Any contribution or forfeiture allocable to your Account after your Benefit Payment Date will be distributed as soon as administratively feasible.

Severance Benefits: If you incur a Break-in-Service at a time when you have a 100% Vested Interest, you are entitled to the amount in your Account as of your Benefit Payment Date. Any contribution or forfeiture allocable to your Account after your Benefit Payment Date will be distributed as soon as administratively feasible. Your Vested Interest in your Account, other than any portion attributable to Elective Deferrals, is determined by your full years of "Vesting Service" in accordance with the following schedule:

Full Years of Vesting Services	Vested Interest
Less than 3 years	0%
3 years or more	100%

You are always 100% vested in any portion of your Account attributable to Elective Deferrals and Rollovers.

Vesting Service: For the period before October 1, 1996, you are credited with Vesting Service in an amount equal to all "vesting service" credited to you under the Pension Plan as it existed on September 30, 1996. For the Plan Year beginning with October 1, 1996, and all Plan Years thereafter, you are credited with one year of Vesting Service for each Plan Year in which you complete 1,000 or more Hours of Service. However, if you complete no more than 400 Hours of Service in any Plan Year, you have a "One-Year Break-in-Service." If, at a time when you do not have any Vested Interest in your Account, you incur 5 consecutive One-Year Breaks-in-Service, your years of Vesting Service prior to the break are

disregarded and the amount in your Account as of such incurrence will become forfeited as of such incurrence.

For purposes of determining whether a One-Year Break-in-Service occurs, there is a special rule for absences from work due to your pregnancy, the birth of your child, your adoption of a child, or your caring for your child during the period immediately following such birth or adoption. You are credited with Hours of Service during such periods of absence in a manner necessary to prevent the occurrence of a One-Year Break-in-Service in the Plan Year in which such absence begins, if you do not otherwise complete 400 Hours of Service during such Plan Year, or in the immediately following Plan Year. As a condition to the crediting of such Hours of Service, the Trustees may require you to furnish appropriate and timely information explaining the reasons for your absence.

14. HOW ARE MY BENEFITS PAID?

Except under the circumstances discussed below, your benefit generally is paid in a lump sum cash payment on your Benefit Payment Date. Your benefit is paid to you unless you die prior to your Benefit Payment Date, in which case your benefit is paid to your designated beneficiary (see Question 15).

Your "Benefit Payment Date" (the date that a payment is made from the Trust Fund to provide your benefit) is as follows:

- with respect to a Retirement Benefit, as to your initial retirement, as soon as administratively feasible after the date you become entitled to such benefit, and as to any subsequent retirement, within sixty days following the close of the Plan Year in which such subsequent retirement occurs;

- with respect to Disability Benefit, as soon as administratively feasible after the date you are entitled to such benefit;

- with respect to a Vested Benefit, as soon as administratively feasible after the last day of the period of three consecutive Plan Years during each of which you are credited with less than 400 Credit Hours; and

- with respect to a Death Benefit, as soon as administratively feasible after the date of your death.

However, if your Vested Interest in your Account exceeds $1,000 and you have not reached 65, died or consented to a distribution within the 90-day period ending on the date payment of your benefit is due, your Benefit Payment Date is deferred to the date that is as soon as administratively feasible after the date upon which you reach 65 or die (or as soon as administratively feasible after any earlier date you may elect by prior written notice to the Trustees).

Your benefit is eligible for direct rollover treatment. Subject to the guidelines provided below, you have the option to request that your benefit be transferred directly to another qualified plan or annuity plan or an individual retirement account or individual retirement annuity (other than an endowment contract) established by you, with any remainder paid directly to you. Your benefit may not be directly transferred to another plan or account unless (a) it equals $200 or more or, if you elect to transfer less than 100% of your benefit, the amount you elect to transfer is at least $500, and (b) if required by the Trustees, you furnish the Trustees with a statement from the plan or account to which the transfer is to be made that it is, or is intended to be, an individual retirement account to which the transfer is to be made that it is, or is intended to be, an individual retirement account, an individual retirement annuity, a qualified plan described in section 401(a) of the Internal Revenue Code, or a qualified annuity plan described in section 403(a) of the Internal Revenue Code, as applicable, and that it will accept the transfer. Any portion of your benefit you elect to have paid directly to you must have 20% withheld for federal income tax by the Plan. The withholding requirement imposed on the Plan is mandatory and you are not allowed to waive it. Only the benefit amount received directly by you is subject to withholding. No withholding is imposed on the portion of your benefit you elect to have transferred directly to another plan or account. You will be provided with more detailed information explaining each payment option and its tax implications prior to receiving any distribution eligible for direct rollover treatment.

If your benefit is payable to your spouse or other designated beneficiary in the event of your death, your spouse or designated beneficiary generally has the same direct rollover rights and withholding requirements as are described above except that the direct rollover may only be made to an individual retirement account or individual retirement annuity.

Due to the complexity and frequency of changes in the federal laws that govern penalties and taxes associated with benefit distributions, a specific explanation of the tax law and IRS rules and regulations is beyond the scope of this summary. You will receive additional information from the Administrator or Plan record keeper at the time of any benefit distribution, and you should consult your tax advisor to determine your personal tax situation before taking the distribution.

15. HOW DO I SELECT A BENEFICIARY?

You may designate a beneficiary or beneficiaries to receive any Plan benefit owing upon your death by executing and filing the prescribed form with the Trustees. Any such designation may be changed at any time by executing and filing a new form with the Trustees. If you are married, your spouse must consent in writing if you designate someone other than your spouse as your primary beneficiary. If you die with no designation in effect, your benefit is paid to your surviving spouse, if any, or otherwise to the executor or administrator of your estate or to your heirs at law.

The Trustees encourage you to review your beneficiary designations from time to time and to complete new Beneficiary Designation Forms in the event of marriage, divorce, or beneficiary death.

16. CAN I ASSIGN ANY OF MY BENEFITS?

Neither you nor your beneficiary may assign, pledge, encumber, or otherwise transfer any of your right or interest of any kind in your benefits. However, the Trustees will comply with the terms of any "qualified domestic relations order" and certain "judgments and settlements" as required under applicable law. A description of the Plan's procedures regarding "qualified domestic relations orders" may be obtained without charge, from the Plan's administrative office.

17. WHAT IS THE CLAIMS REVIEW PROCEDURE UNDER THE PLAN?

If a participant or spouse submits an application for benefits, any claim for plan benefits filed and any review of such claim which is denied or modified will be processed in accordance with the written plan claims procedures established by the trustees. These procedures are attached to this summary plan description as "Appendix A" for your information and use.

18. CAN THE PLAN BE AMENDED?

The Trustees reserve the right to amend the Plan at any time on behalf of the Employers and the Union.

19. WHAT ARE MY RIGHTS UPON PLAN TERMINATION?

Plan termination insurance under Title IV of the Employee Retirement Income Security Act of 1974 ("ERISA") does not apply to this Plan since Members' interests are maintained in individual accounts.

The Trustees have established the Plan with the intention and expectation that from year to year Employers will be able to and will deem it advisable to, make contributions as required. However, the Trustees realize that circumstances not now foreseen, or circumstances beyond their control, may make it either impossible or inadvisable for Employers to continue to make contributions. Therefore, the Trustees have the power to terminate the Plan at any time.

If contributions to the Plan are discontinued or if the Plan is terminated or partially terminated with respect to your interest, you will be entitled to 100% of the amount in your Account. Upon such discontinuance or termination, any previously unallocated contributions or forfeitures would be allocated to your Account on the date of discontinuance or termination. In the case of discontinuance, distribution would occur as otherwise provided in the Plan. In the

case of termination, distribution would occur as soon as practicable following Internal Revenue Service approval.

20. WHAT ARE MY RIGHTS UNDER ERISA?

As a Member of the Maritime Association – I.L.A. Retirement Plan, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants shall be entitled to:

- Examine without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.
- Obtain a statement telling you of your vested rights under the Plan. If you do not have such vested rights, the statement will tell you how many more years you have to work to get vested rights. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of employee benefit plans. 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, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits of exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator 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 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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 that your claim is frivolous).

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, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

21. WHAT OTHER FACTS SHOULD I KNOW?

Fiscal Year of Plan	October 1 through September 30
Type of Plan	Individual account defined contribution plan
Plan No.	002
Plan Sponsor	Trustees of the Maritime Association – I.L.A. Retirement Plan 11550 Fuqua, Suite 425, Houston, TX 77034
Plan Administrator	Trustees of the Maritime Association – I.L.A. Retirement 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
Trustees	Mark Bridges Adam Brooks Eloy Cortez Jay Cromie Thomas Griffith Gabriel Garza Benjamin Green Don Johnson Shareen Larmond Charles Lewis Chris Lewis Charles Montgomery Dave Morgan Larry Sopchak Randy Stiefel Shane Taylor Chelsea Wauson

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.

SI USTED NO ENTIENDE ALGUNAS DE LAS PROVISIÓNES INDICADES EN EL FOLLETO POR FALTA DE COMPRENSIÓN DEL IDIOMA INGLES, ASISTENCIA Y EXPLICACIÓN DE LAS PROVISIÓNES DEL PLAN SERAN EXPLICADES POR LA OFICINA ADMINISTRATIVA LOCADA EN:

11550 Fuqua Street, Suite 425
Houston, TX 77034
Telefono: (281) 484-4343

APPENDIX "A"

CLAIMS PROCEDURES FOR
THE MARITIME ASSOCIATION – I.L.A.
PENSION AND RETIREMENT PLANS

I. **Purpose**. This document sets forth the benefit claims procedures adopted by the Board of Trustees of the Maritime Association – I.L.A. Pension, Retirement, Welfare & Vacation Funds, respecting the Pension and Retirement Plans set forth on Schedule A hereto.

II. **Definitions**. For purposes of these procedures, the following terms, when capitalized, will be defined as follows:

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

(2) Benefits Administrator: The person or office to whom the Board of Trustees has delegated day-to-day Plan administration responsibilities and who, pursuant to such delegation, processes Plan benefit claims in the ordinary course.

(3) Board of Trustees: The Board of Trustees of the Maritime Association – I.L.A. Pension, Retirement, Welfare & Vacation Funds, charged with administering the Plan.

(4) Claimant: A Member or beneficiary or an authorized representative of such Member or beneficiary who has filed or desires to file a claim for a Plan benefit.

(5) Employer: The applicable entity employing the Members.

(6) Effective Date: April 1, 2018, as to this amendment and restatement of the benefit claims procedures adopted by the Board of Trustees.

(7) ERISA: The Employee Retirement Income Security Act of 1974, as amended.

(8) Health Care Professional: A physician or other health care professional licensed, accredited or certified to perform specific health services consistent with state law.

(9) Independent Fiduciary: The person or entity retained by the Board of Trustees to perform the review of an Adverse Benefit Determination, who will be a person or entity other than (a) the person or entity that made the Adverse Benefit Determination that is subject of the review and (b) the subordinate of such person or entity.

(10) Member: An individual who has an accrued benefit or an account under the Plan. Such individual may be referred to as a "member" or "participant" under the applicable Plan.

(11) Plan: Each Plan, as designated by the Board of Trustees and as set forth on Schedule A hereto, separately and respectively.

(12) Relevant Information: All documents, records and other information relevant to a Claimant's claim for benefits under the Plan. A document, record or other information shall be considered "relevant" to a Claimant's claim for benefits under the Plan if such document, record or other information: (i) was relied upon in making an Adverse Benefit Determination; (ii) was submitted, considered, or generated in the course of making an Adverse Benefit Determination, without regard to whether such document, record or other information was relied upon in making the Adverse Benefit Determination; (iii) demonstrates, in connection with an Adverse Benefit Determination, compliance with the administrative processes and safeguards designed to ensure and verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated Claimants; or (iv) in the case of a claim for disability benefits, constitutes a statement of policy or guidance with respect to the Plan concerning a denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Adverse Benefit Determination.

III. **Filing of Benefit Claim**. To file a benefit claim under the Plan, a Claimant must obtain from the Benefits Administrator the information and benefit claim forms, if any, provided for in the Plan and otherwise follow the procedures established from time to time by the Board of Trustees or the Benefits Administrator for claiming Plan benefits. For purposes of applying the time periods for benefit determination pursuant to Section IV below, filing a claim with the Benefits Administrator will be treated as filing a claim with the Board of Trustees or with the Independent Fiduciary, as applicable. If, after reviewing the information so provided, the Claimant needs additional information regarding his Plan benefits, he may obtain such information by submitting a written request to the Benefits Administrator the benefit claim

forms, if any, provided for in the Plan and otherwise following the procedures established from time to time by the Board of Trustees or the Benefits Administrator for claiming Plan benefits. In connection with the submission of a claim, the Claimant may examine the Plan and any other relevant documents relating to the claim, and may submit written comments relating to such claim to the Benefits Administrator coincident with the filing of the benefit claim form. Failure of a Claimant to furnish written proof of loss or to comply with the claim submission procedure will invalidate such claim unless the Benefits Administrator in its discretion determines that it was not reasonably possible to provide such proof or comply with such procedure.

IV. **Processing of Benefit Claim**. Upon receipt of fully completed benefit claim forms from a Claimant, the Benefits Administrator shall determine if the Claimant's right to the requested benefit, payable at the time or times and in the form requested, is clear and, if so, shall process such benefit claim without resort to the Board of Trustees. If the Benefits Administrator determines that the Claimant's right to the requested benefit, payable at the time or times and in the form requested, is not clear, it shall refer the benefit claim to the Board of Trustees for review and determination, which referral shall include:

(1) All materials submitted to the Benefits Administrator by the Claimant in connection with the claim;

(2) A written description of why the Benefits Administrator was of the view that the Claimant's right to the benefit, payable at the time or times and in the form requested, was not clear;

(3) A description of all Plan provisions pertaining to the benefit claim;

(4) Where appropriate, a summary as to whether such Plan provisions have in the past been consistently applied with respect to other similarly situated Claimants; and

(5) Such other information as may be helpful or relevant to the Board of Trustees in its consideration of the claim.

If the Claimant's claim is referred to the Board of Trustees, the Claimant may examine any relevant document relating to his claim and may submit written comments or other information to the Benefits Administrator, on behalf of the Board of Trustees, to supplement his benefit claim. Within 30 days of receipt from the Benefits Administrator of a benefit claim referral (or such longer period as may be necessary due to unusual circumstances or to enable the Claimant to submit comments), but in any event not later than will permit the Board of Trustees sufficient time to fully and fairly consider the claim and make a determination with the time frame provided in Section VI below, the Board of Trustees shall consider the referral regarding the claim of the Claimant and make a decision as to whether it is to be approved, modified or denied. If the claim is approved, the Board of Trustees shall direct the Benefits Administrator to process the approved claim as soon as administratively practicable.

V. **Notification of Adverse Benefit Determination**. In any case of an Adverse Benefit Determination of a claim for a Plan benefit, the Benefits Administrator, on behalf of the Board of Trustees, shall furnish the affected Claimant (within the notification periods described in Section VI below and, in the case of a claim for disability benefits, in a culturally and linguistically appropriate manner as described in Section XII below) with written or electronic notification of such Adverse Benefit Determination; provided, however, that any electronic notification shall comply with the standards required under the applicable regulations promulgated under ERISA. Any notice that denies a benefit claim of a Claimant in whole or in part shall, in a manner calculated to be understood by the Claimant:

(1) State the specific reason or reasons for the Adverse Benefit Determination;

(2) Provide specific reference to pertinent Plan provisions on which the Adverse Benefit Determination is based;

(3) Describe any additional material or information necessary for the Claimant to perfect the claim and explain why such material or information is necessary;

(4) Describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review; and

(5) With respect to a claim for a disability benefit:

i. include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the Claimant to the Plan of Health Care Professionals treating the Claimant and vocational professionals who evaluated the Claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's benefit determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and (iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;

ii. if the Adverse Benefit Determination is based on an exclusion or limit, either explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or state that such explanation will be provided free of charge to the Claimant upon request;

iii. provide either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan that was relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such

rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

iv. state that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Relevant Information.

VI. **Timing of Adverse Benefit Determination Notification**. As to claims other than as described in the paragraph below, a Claimant will be notified by the Benefits Administrator of an Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after receipt of such claim for Plan benefits (or within 180 days if special circumstances necessitate an extension of the 90-day period and the Claimant is informed of such extension by the Benefits Administrator in writing within the 90-day period and is provided with an extension notice consisting of an explanation of the special circumstances requiring the extension of time and the date by which the benefit determination will be rendered).

As to claims for disability benefits, a Claimant will be notified by the Benefits Administrator of an Adverse Benefit Determination within a reasonable period of time, but not later than 45 days after receipt of the claim. This period may be extended by the Benefits Administrator for up to 30 days, provided that the Benefits Administrator both determines that such extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Benefits Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days provided that the Benefit Administrator notifies the Claimant prior to the expiration of the first 30 days provided that the Benefits Administrator notifies the Claimant prior to the expiration of the first 30 day extension period of the circumstances requiring the extension and the date of which the Plan excepts to render a decision. Any extension notice provided to a Claimant shall specifically explain the standards on which entitlement to the benefit at issue is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant shall be afforded at least 45 days in which to provide the specific information. In the event of such an extension, the period for making the Adverse Benefit Determination will be tolled from the date on which the notification of extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

The periods of time within which an Adverse Benefit Determination shall be made, as described above, shall begin at the time a claim is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

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

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

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

(2) The Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits to the Benefits Administrator, on behalf of Board of Trustees;

(3) The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all Relevant Information; and

(4) The Claimant shall have the right to have all comments, documents, records, and other information submitted by the Claimant relating to the claim for benefits considered on review without regard to whether such comments, documents, records or information was considered in the initial benefit determination.

As to claims for disability benefits:

(1) To exercise the right to request a review of an Adverse Benefit Determination, a Claimant must initially submit a written request for such review to the Benefits Administrator, on behalf of Board of Trustees, not later than 180 days following receipt by the Claimant of the Adverse Benefit Determination notification;

(2) If such initial review results in an Adverse Benefit Determination, a Claimant may request a subsequent review of the Adverse Benefit Determination by an Independent Fiduciary by submitting a written request for such review to the Benefits Administrator, on behalf of the Independent Fiduciary, not later than 180 days following receipt by the Claimant of such Adverse Benefit Determination;

(3) The Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits to the Benefits Administrator, on behalf of Board of Trustees or, as applicable, the Independent Fiduciary;

(4) The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all Relevant Information;

(5) The Claimant shall have the right to have all comments, documents, records, and other information submitted by the Claimant relating to the claim for benefits considered on review without regard to whether such comments,

documents, records or information was considered in the initial benefit determination;

(6) The review of the Adverse Benefit Determination shall not give deference to the original decision;

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

(8) The Claimant shall have the right to have identified to him the medical or vocational experts whose advice was obtained in connection with the Adverse Benefit Determination (without regard to whether the advice was relied upon in making such determination);

(9) If the Independent Fiduciary conducting the review considers, relies upon, or generates (or directs the consideration of, reliance upon, or generation of) any new or additional evidence that was not considered, relied upon, or generated in connection with the initial benefit determination, then the Independent Fiduciary conducting the review shall (before such Independent Fiduciary can issue an Adverse Benefit Determination on review of the claim) provide the Claimant with such new or additional evidence free of charge (which evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notification of Adverse Benefit Determination on review is required to be provided under Section VIII below to give the Claimant a reasonable opportunity to respond prior to that date); and

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

The decision on review by the Benefits Administrator or Independent Fiduciary, as applicable, pursuant to the preceding paragraphs of this Section VII will be binding and conclusive upon all persons, and the Claimant shall neither be required nor be permitted to pursue further appeals to the Benefits Administrator or Independent Fiduciary, as applicable.

VIII. **Notification of Benefit Determination on Review**. Notice of the Board of Trustees' or the Independent Fiduciary's, as applicable, benefit determination regarding review of an Adverse Benefit Determination will be furnished by the Benefits Administrator to the Claimant after a full and fair review in writing or electronically and, in the case of a claim for disability benefits, in a culturally and linguistically appropriate manner as described in Section XII below; provided, however, that any electronic notification shall comply with the standards required under the applicable regulations promulgated under ERISA. Notice of an Adverse Benefit Determination upon review will:

(1) State the specific reason or reasons for the Adverse Benefit Determination;

(2) Provide specific reference to pertinent Plan provisions on which the Adverse Benefit Determination is based;

(3) State that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Relevant Information; and

(4) Describe the Claimant's rights to bring an action under section 502(a) of ERISA.

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

(1) Describe any applicable contractual limitations period that applies to the Claimant's right to bring an action under section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim;

(2) Provide either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan that was relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(3) If the Adverse Benefit Determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or state that such explanation will be provided free of charge to the Claimant upon request;

(4) Include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the Claimant to the Plan of Health Care Professionals treating the Claimant and vocational professionals who evaluated the Claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's benefit determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and

(iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration; and

(5) Include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

As to claims other than as described in the paragraph below, the Benefits Administrator, on behalf of Board of Trustees, shall notify a Claimant of the Board of Trustees' determination on review with respect to the Adverse Benefit Determination of the Claimant not later than the date of the meeting of the Board of Trustees which immediately follows the request for review or, if such request for review is filed within 30 days of such meeting, not later than the date of the second meeting of the Board of Trustees which immediately follows such request for review, unless the Benefits Administrator determines that special circumstances require an extension of time for processing such review. If the Benefits Administrator determines that such extension of times is required, written notice of the extension (which shall indicate the special circumstances requiring the extension and the date by which the Board of Trustees expects to render the determination on review) shall be furnished by the Benefits Administrator to the Claimant prior to the termination of the above-described review period. Such extension shall run until the third meeting of the Board of Trustees following receipt of such request for review. In the event such extension is due to the Claimant's failure to submit necessary information, the period for making the determination on a review will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

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

sent to the Claimant until the date on which the Claimant responds to the request for additional information.

IX. **Exhaustion of Administrative Remedies**. Completion of the claims procedures described in this document will be a condition precedent to the commencement of any legal or equitable action in connection with a claim for benefits under the Plan by a Claimant or by any other person or entity claiming rights individually or through a Claimant; provided, however, that the Board of Trustees may, in its sole discretion, waive compliance with such claims procedures as a condition precedent to any such action.

X. **Payment of Benefit**. If the Benefits Administrator, Board of Trustees or Independent Fiduciary, as applicable, determines that a Claimant is entitled to a benefit hereunder, payment of such benefit will be made to such Claimant (or commence, as applicable) as soon as administratively practicable after the date the Benefits Administrator, Board of Trustees or Independent Fiduciary, as applicable, determines that such Claimant is entitled to such benefit or on such other date as may be established pursuant to the Plan provisions or, as applicable, designated by the Board of Trustees or Independent Fiduciary.

XI. **Authorized Representatives**. An authorized representative may act on behalf of a Claimant in pursuing a benefit claim or an appeal of an Adverse Benefit Determination. An individual or entity will only be determined to be a Claimant's authorized representative for such purposes if the Claimant has provided the Benefits Administrator a written statement identifying such individual or entity as his authorized representative and describing scope of the authority of such authorized representative. In the event a Claimant identifies an individual or entity as his authorized representative in writing to the Benefits Administrator but fails to describe the scope of the authority of such authorized representative, the Benefits Administrator shall assume that such authorized representative has full powers to act with respect to all matters pertaining to the Claimant's benefit claim under the Plan or appeal of an Adverse Benefit Determination with respect to such benefit claim.

XII. **Culturally and Linguistically Appropriate Notices**. If the claims procedures described in this document require a notice with respect to a claim for disability benefits to be provided in a culturally and linguistically appropriate manner in accordance with this Section, then the notice shall satisfy the following requirements with respect to the applicable non-English languages described in the following sentence: (i) the Plan must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any non-applicable English language; (ii) the Plan must provide, upon request, a notice in any applicable non-English language; and (iii) the Plan must include in English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. With respect to an address in any United States county to which a notice is sent, a non-English language is an "applicable non-English language" if 10% or more of the population residing in the county is literate only in the same non-English language, as determined in guidance provided by the Department of Labor.

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

XIV. **Applicability Dates**. Notwithstanding any provision herein to the contrary, (i) the amended and restated claims procedures provided in this document shall apply to claims for benefits under the Plan filed on or after the Effective Date and (ii) the provisions of the corresponding claims procedures as in effect immediately prior to the Effective Date shall apply to claims for benefits under the Plan filed prior to the Effective Date.

XV. **Amendments**. These claims procedures have been adopted by the Board of Trustees as part of the Plan. They may be amended by the Board of Trustees from time to time in its sole discretion.

SCHEDULE A
PENSION AND RETIREMENT PLANS
OF THE MARITIME ASSOCIATION – I.L.A.

1. Maritime Association – I.L.A. Pension, Retirement, Welfare & Vacation Funds Pension Plan

2. Maritime Association – I.LA. Pension Plan

3. Maritime Association – I.LA. Retirement Plan

4. Maritime Association – I.L.A. Pension, Retirement, Welfare & Vacation Funds Retirement Plan

APPENDIX B

"RETIREMENT PLAN CONTRIBUTION CREDITING RATES"

Effective Date:
October 1, 2019

Cargo	Regular	New Entry	Basic	Addt'l Basic	Special
Fully Automated	$4.00	$2.00	$1.00	$1.00	$0.50 through 1-31-06 $1.00 after 2-1-06
Non-Fully Automated	$4.00	$2.00	$1.00	$1.00	$0.50 through 1-31-06 $1.00 after 2-1-06
USMX Supplemental for Plan Years ending 9-30-06 and 9-30-07	$.75	$.75	$.75		$.75
USMX Supplemental for Plan Year ending 9-30-08	$1.00	$1.00	$1.00		$1.00
USMX Supplemental for Plan Year ending 9-30-09	$1.50	$1.50	$1.50		$1.50
USMX Supplemental for Plan Year ending 9-30-10	$4.65[1]	$4.65	$4.65		$4.65
USMX Supplemental for Plan Year ending 9-30-11	$3.39	$3.39	$3.39		$3.39
USMX Supplemental for Plan Year ending 9-30-12	$2.753	$2.753	$2.753		$2.753
USMX Supplemental for Plan Year ending 9-30-13	$2.926	$2.926	$2.926		$2.926
USMX Supplemental for Plan Year ending 9-30-14	$2.7849	$2.7849	$2.7849		$2.7849
USMX Supplemental for Plan Year ending 9-30-15	$2.4835	$2.4835	$2.4835		$2.4835
USMX Supplemental for Plan Year ending 9-30-16	$2.869	$2.869	$2.869		$2.869
USMX Supplemental for Plan Year ending 9-30-17	$2.6902	$2.6902	$2.6902		$2.6902
USMX Supplemental for Plan Year ending 9-30-18	$2.449	$2.449	$2.449		$2.449
USMX Supplemental for Plan Year ending 9-30-19	$2.6114	$2.6114	$2.6114		$2.6114
Supplemental Employer Contribution for Plan Year ending 9-30-19	$.6226	$.6226	$.6226		$.6226

[1] The amount stated in the table as "$4.65" is the rounded amount of the USMX Supplemental for the Plan Year ending 9-30-10 for each of Regular, New Entry, Basic and Special categories, and the un-rounded amount used for the special allocation calculations with respect thereto is $4.646177542.