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This booklet summarizes eligibility and benefits under the ILWU-PMA Welfare Plan. The booklet does not describe eligibility requirements and benefit provisions in complete detail. The information in this booklet is subject to, and in no way modifies or interprets, the provisions of the ILWU-PMA Welfare Agreement and the provisions of policies of insurance and contracts between the Welfare Plan Trustees and the insurance carriers and providers of care. This booklet and the Supplemental Summary Plan Description booklets mentioned on page 17 together summarize the provisions of the ILWU-PMA Welfare Plan through the 2014-2022 ILWU-PMA collective bargaining agreements.

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A Message From the Trustees

The Trustees are pleased to provide you with this Summary Plan Description, which summarizes the eligibility requirements, benefits, and claims review procedures of the ILWU-PMA Welfare Plan. It also provides important information about the operation of the Plan, and about the rights of Plan Participants under the law.

This Summary Plan Description includes the provisions of the Plan adopted by the parties to conform the Plan with the Employee Retirement Income Security Act of 1974 (ERISA). It reflects provisions established through the most recent (2014–2022) ILWU-PMA Collective Bargaining Agreements.

Please write to the Benefit Plans Office if you have any questions about the Welfare Plan or the Summary Plan Description.

ILWU-PMA Welfare Plan benefits for eligible Longshoremen, Marine Clerks, and Walking Bosses/Foremen are established by collective bargaining between the International Longshore and Warehouse Union (ILWU) and Pacific Maritime Association (PMA). Copies of the Welfare Agreement are on file at the Benefit Plans Office, are furnished to ILWU Locals and are available to Participants and beneficiaries on request. The information in the Summary Plan Description booklet is subject to, and in no way modifies or interprets, the provisions of the ILWU-PMA Welfare Agreement. To the extent there is any ambiguity, difference or inconsistency between this Summary Plan Description and the Welfare Agreement, the provisions of the Welfare Agreement shall govern.

Where the masculine or feminine gender is used in the Summary Plan Description, its use is meant to be applicable to both genders.

The Definitions beginning in Section L on page 37 explain some of the terms used in this Summary Plan Description.

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ILWU-PMA Welfare Plan (Welfare Plan) programs for eligible Longshore Workers, Marine Clerks, Walking Bosses/Foremen, Watchmen, and certain employees of the International Longshore and Warehouse Union (ILWU), the ILWU-PMA Benefit Plans Office (Benefit Plans Office), the ILWU locals, and their qualified dependents, are established by collective bargaining between the ILWU and the Pacific Maritime Association (PMA). The Welfare Plan provides the following types of benefits: health care (including hospital-medical-surgical care, prescription drugs, vision care, hearing aids, and dental care), death and accidental death and dismemberment, time loss (weekly indemnity and supplemental disability), alcoholism/drug recovery, and Social Security supplementation. Please see the Table of Contents for reference to Plan eligibility, benefit programs, claims review procedures, and general information. Welfare Plan provisions are set forth in the ILWU-PMA Welfare Agreement, as amended, which is the collective bargaining agreement under which the Plan is maintained. To the extent this booklet is inconsistent with the Agreement, the Agreement shall govern. Copies of the Agreement are on file at the Benefit Plans Office, are furnished to ILWU locals, and are available to participants and beneficiaries upon request.

GRANDFATHERED HEALTH PLAN

Please note that the Trustees believe that the Welfare Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for independent review of denial by an organization that has no connection to the Plan. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Although it is a "grandfathered health plan", you should know that the Welfare Plan provides health coverage benefits beyond the "basic" level of benefits and has long maintained many consumer protections now required under the Affordable Care Act. For example, the Welfare Plan has always prohibited rescissions of coverage due to a member's health condition as well as exclusions for pre-existing conditions for children and adults. There is also no "waiting period" for benefit eligibility once a member attains initial coverage based on registration or hire. Nor does the Welfare Plan discriminate in favor of certain members based on compensation or health status.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the ILWU-PMA Benefit Plans Office, at 415-673-8500. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Section A:

Who is Eligible for ILWU-PMA Welfare Plan Benefits

Although each Welfare Plan program may have different and additional requirements for coverage, the Plan's basic eligibility is determined as follows, subject always to the termination provisions on pages 11-13:

Active Employees

A description of eligibility requirements for Participants who are Active Employees begins on page 9.

Dependents

If you are a Dependent Spouse or Dependent Child of a Participant, you have Welfare Plan eligibility, provided that you have been identified as a Dependent Spouse or Dependent Child by the Participant on the form provided by and filed with the Trustees. Your eligibility as a dependent shall continue as long as the person through whom you claim eligibility remains eligible, or until you cease to be qualified for dependent status. See "Special Tax Rule for Certain Dependents," below.

If you are a Participant with dependents, please know that by identifying an individual as your Dependent Spouse or Dependent Child for Welfare Plan benefits, you are certifying that the individual is your Dependent Spouse or Dependent Child and that all information on the applicable form is true and correct. You must also agree to provide any additional information that the Trustees may require for verification purposes. Specifically, you will be required to certify to the following statement: "I understand that if I misstate or misrepresent any information on an enrollment form, my dependents and I may each lose eligibility for benefits under the ILWU-PMA Welfare Plan."

Pensioners

Most Active Employees who become Pensioners have Welfare Plan eligibility beginning on the day they become Pensioners. It is expected that eligibility will continue until the Pensioner loses eligibility as explained on page 12.

Surviving Dependent Spouse or Surviving Dependent Children of Deceased Active Employees with Fewer than 5 Years of Vested Service Under Either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan

If you are neither an Adult Dependent Spouse Survivor nor a Dependent Child Survivor, but you are a Surviving Dependent Spouse or Surviving Dependent Child of a deceased eligible Active Employee, you have Welfare Plan eligibility for four years immediately following the Active Employee's death if the Active Employee was credited with fewer than five (5) qualifying years of service under either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan. You must have been enrolled as the Dependent Spouse or Dependent Child of the Active Employee as of the date of the Active Employee's death. A Surviving Dependent Spouse may continue Welfare Plan coverage after the four-year period has ended by purchasing it under terms and conditions determined by the Trustees. Welfare Plan eligibility ends when the Surviving Dependent Spouse remarries. See "Special Tax Rule for Coverage For Certain Dependents," on page 4.

Adult Dependent Spouse Survivors of Deceased Pensioners or Active Employees with at Least 5 Years of Vested Service Under Either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan

If you are a surviving spouse receiving a Survivor Pension (but not an Early Survivor Annuity) under either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan, you have Welfare Plan eligibility for yourself as an Adult Dependent Spouse Survivor and for your qualified Dependent Children provided that the pension is claimed through a Pensioner who had Welfare Plan eligibility when he or she died and you are identified by the Pensioner as his or her Dependent Spouse on the form provided by and filed with the Trustees as of the date of the Pensioner's death. (Note that evidence of marital status is required in order to add a Dependent Spouse – see page 38 under the definition of Dependent Spouse for a description of the required documentation.)

You may also be eligible for Welfare Plan benefits if you were a surviving spouse of a deceased Active Employee if, as of the date of the Active Employee's death, (1) you were identified by the Active Employee as his or her Dependent Spouse on the form provided by and filed with the Trustees as of the date of the Active Employee's death, (2) the Active Employee was registered, (3) the Active Employee was credited with 5 years of vested service under either the ILWU-PMA Pension Plan or ILWU-PMA Watchmen Pension Plan, and (4) the Active Employee worked in a capacity for which a contribution was required under either the ILWU-PMA Pension Plan or ILWU-PMA Watchmen Pension Plan, or was credited as if he or she had so worked, in each of the 5 years preceding or ending with the year of his or her death. If the only reason the Active Employee did not work in each of those 5 years was because of a continuous illness or injury, he or she must have worked or been credited in at least 3 of the 5 years, or the Trustees must determine that his or her continuous illness or injury was so serious that the Active Employee (continuously after he last earned a qualifying year of service under the Pension Plan due to his or her serious illness or injury) could not have worked, and in fact did not work, in the longshore industry or in any other occupation requiring similar skills, training and experience.

Welfare Plan eligibility ends as an Adult Dependent Spouse Survivor (both for yourself and your dependent children) when you remarry. If your eligibility is terminated due to remarriage, you may not re-qualify as an Adult Dependent Spouse Survivor if you annul your marriage unless the Trustees are satisfied that the remarriage was annulled for reasons other than re-establishing your status as an Adult Dependent Spouse Survivor.

Dependent Child Survivors of Deceased Pensioners or Active Employees with at Least 5 Years of Vested Service Under Either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan

If you were enrolled as a Dependent Child of a Pensioner as of the date of the Pensioner's death, you have Welfare Plan eligibility as a Dependent Child Survivor for the period you receive survivor pension benefits under either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan.

If you were enrolled as a Dependent Child of an Active Employee as of the date of the Active Employee's death, you have Welfare Plan eligibility as a Dependent Child Survivor for the period you receive survivor pension benefits under the ILWU-PMA Pension Plan, if, as of the date of the Active Employee's death, (1) the Active Employee was registered, (2) the Active Employee was credited with 5 years of vested service under either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan, and (3) the Active Employee worked in a capacity for which a contribution was required under either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan, or was credited as if he or she had so worked, in each of the 5 years preceding or ending with the year of his or her death. If the only reason the Active Employee did not work in each of those 5 years was because of a continuous illness or injury, he or she must have worked or been credited in at least 3 of the 5 years, or the Trustees must determine that the Active Employee's continuous illness or injury was so serious that the Active Employee (continuously after he last earned a qualifying year of service under either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan due to his serious illness or injury) could not have worked, and in fact did not work, in the longshore industry or in any other occupation requiring similar skills, training and experience.

Surviving ERISA Spouses of Deceased Pensioners

If you are a surviving spouse of a Pensioner who died on or after July 1, 1987, were married to such Pensioner for at least one year as of the Pensioner's date of death, were identified by the Pensioner as a Dependent Spouse on the form provided by and filed with the Trustees as of the date of the Pensioner's death, and are neither an Adult Dependent Spouse Survivor (but you would have qualified as an Adult Dependent Spouse Survivor under ERISA before the laws were changed in 1984), nor a Surviving Dependent Spouse, you have Welfare Plan eligibility. Welfare Plan eligibility ends as a Surviving ERISA Spouse when you remarry.

Special Tax Rule for Coverage for Certain Dependents

Certain dependents who are eligible for Welfare Plan benefits do not meet the definition of "dependent" in the Internal Revenue Code and corresponding state tax laws. Participants who certify these persons as Dependents are responsible for applicable income and payroll taxes due for these dependents because the fair market value of their Welfare Plan coverage may be considered by the Internal Revenue Service and/or state tax agencies to be taxable income (wages) to Participants depending on the particular circumstances and the dependent relationship. Payment of these taxes is a condition of coverage for the dependent of the participant or retiree. Agreement to allow the value of these benefits to be considered as taxable, imputed income on the Participant's W-2 tax filings is a condition of coverage for these dependents.

Such dependents can include certain children who are not financially dependent on the Participant. If, however, your Dependent Spouse and Dependent Children qualify as "dependents" under Section 152 of the Internal Revenue Code, the value of their coverage is not taxable income. Because the tax implications will be different based on the dependent relationship and may also vary from state to state, for detailed information on how and whether such tax rules will apply to you, please refer to the Important Tax Notice to Active and Retired Participants in the ILWU-PMA Welfare Plan. This notice is available from the Benefit Plans Office.

You must report all changes in family status that might affect Welfare Plan eligibility (such as marriage, final dissolution of marriage, birth, adoption, death of a dependent) to the Benefit Plans Office.

Medicare Enrollment

The Welfare Plan hospital-medical-surgical programs are integrated with primary Medicare coverage. Active Employees and their dependents age 65 and over are covered primarily under the Welfare Plan until retirement, in accordance with federal law. Thus, Pensioners and their dependents with Welfare Plan eligibility must, if eligible, enroll in Part B of Medicare in order to maintain their eligibility for Welfare Plan hospital, medical and surgical benefits. You can enroll in Medicare Part A and/or Part B in the following ways: Online at **www.SocialSecurity.Gov**; by calling 800-772-1213; or in person at your Social Security Office. Information regarding the enrollment procedure is available from the Benefit Plans Office.

The Welfare Plan reimburses the cost of Medicare Part B premiums, unless otherwise reimbursed, to Pensioners, Adult Dependent Spouse Survivors, Surviving Dependent Spouses, Surviving ERISA Spouses and dependents who are required to enroll in Medicare Part B in order to maintain Welfare Plan coverage.

Section B:

How Eligibility for Plan Benefits is Determined for Active Employees

Only persons who have industry Registration may become eligible as Active Employees for Welfare Plan benefits, except as provided in "Non-Registered Active Employees" on page 7. Following is a summary of the rules by which Active Employees' eligibility is established.

Annual Review

The Trustees conduct a review of each registered Active Employee's employment record in covered employment for the Payroll Year preceding each July 1 to determine whether the employee has established eligibility for Welfare Plan coverage for the 12 months beginning as of such July 1.

Eligibility Rules for Major Ports: On July 1 of each year, if you are a registered Active Employee whose Assigned Port is a Major Port, you will be eligible during the succeeding 12 calendar months if you work or are credited with at least 800 hours in the preceding Payroll Year, or at least 400 hours in the last half of the preceding Payroll Year. (See definition of Assigned Port on page 37 and of Major Port on page 38.)

Eligibility Rules for Minor Ports: On July 1 of each year, if you are a registered Active Employee whose Assigned Port is a Minor Port, you will be eligible during the succeeding 12 calendar months if you work or are credited with at least 480 hours in the preceding Payroll Year, or at least 240 hours in the last half of the preceding Payroll Year. (See definition of Minor Port on page 38.)

Mid-Year Review

The Trustees conduct a review of each ineligible registered Active Employee's employment record in covered employment for the first half of the Payroll Year preceding each January 1 to determine whether the employee has established eligibility for Welfare Plan coverage for the 6 months beginning as of such January 1.

Eligibility Rule for Major Ports: On January 1 of each year, if you are a registered Active Employee whose Assigned Port is a Major Port, you will be eligible during the succeeding 6 calendar months if you work or are credited with at least 400 hours in the first half of the preceding Payroll Year.

Eligibility Rules for Minor Ports: On January 1 of each year, if you are a registered Active Employee whose Assigned Port is a Minor Port, you will be eligible during the succeeding 6 calendar months if you work or are credited with at least 240 hours in the first half of the preceding Payroll Year.

Pay Guarantee Credits

If you are a registered Active Employee who is eligible for payments under either the Pay Guarantee Plans or the Clerks Working Opportunity Guarantee (CWOG) Program during a review period, you will be credited toward the hours requirement for eligibility with all payments for which you are eligible. The credit is determined by dividing the total amount of payments for which you are eligible during the review period by the hourly straight-time wage rate then in effect.

B

Disability Credits

If you are a registered Active Employee with a disabling illness or injury that prevents you from meeting the hours requirement of an Annual or Mid-year Review for Welfare Plan eligibility, you may be credited with additional hours during the term of a certified disability.

1. If you have been unable to meet the hours requirement for eligibility because of a certified disability, but you have worked or been credited with at least 25% of the hours requirement of an Annual or Mid-year Review, you will be credited with additional hours during the review period as follows: the total number of credited hours will be the result of multiplying the number of weeks of credited disability by the average number of hours per week you worked or were credited during the review period. This average is determined by dividing the total number of hours worked or credited during the review period by the number of weeks in the review period, excluding the period of disability
2. If you were eligible immediately prior to an Annual Review date, but because of a continuous certified disability in the review period, you were unable to work any hours, or you worked or were credited with less than 25% of the hours required on an Annual Review, you may be credited with hours sufficient to establish your eligibility at the Annual Review.
    (a) If the disability is due partly or wholly to a job-connected illness or injury for which you receive industrial compensation (such as medical or time loss benefit payments), you may be so credited while the disability continues with hours to establish eligibility for a maximum of five consecutive years.
    (b) If the disability is not due to a job-connected illness or injury for which you receive industrial compensation, you may be so credited while the disability continues for a maximum of five consecutive years. The Trustees, or their delegate, will certify through independent examinations/reviews welfare eligibility for the fourth and fifth years of disability.

If you exhaust the maximum period of eligibility, you can re-establish Welfare eligibility only by working, or being otherwise credited with the hours required on an Annual or Mid-year Review (excluding any disability credits that might be available under paragraph 1).

3. If you seek disability credits toward Welfare Plan eligibility, you must annually submit evidence satisfactory to the Trustees that certifies your disability for the period claimed and that establishes whether or not the disability is the result of a job-connected illness or injury for which industrial compensation was received. Such evidence must include a doctor's report or a report from a health care practitioner licensed to make disability findings. You may submit this evidence (information or documents) either to the Joint Port Labor Relations Committee of your Assigned Port or to the Welfare Plan Trustees. The Trustees will notify you of their determination whether to grant any hours of credit toward eligibility.

Leave of Absence and Other Credits

You may receive credit toward the hours requirement for eligibility for the period of an authorized Leave of Absence (due to disability, illness, or injury) of less than 90 days. Such credit is computed on the same basis as described in paragraph 1 under Disability Credits. Other credits are available as described in the Welfare Agreement, including credits for employment by the parties or union, military and other leaves of absence, and travel time lost.

Please note that if you are an Active Employee who is on an approved leave under the Family and Medical Leave Act of 1993 (FMLA), you have the right to continue coverage under the Welfare Plan during the leave; however, you will not receive credit towards the hours requirement for Welfare Plan eligibility during the period of an FMLA leave. For more information, contact the Benefit Plans Office to determine Welfare Plan eligibility under FMLA.

Non-Registered Active Employees

If you are a Container Freight Station (CFS) steady employee who is registered and not otherwise eligible as an Active Employee, a CFS and Maintenance and Repair steady employee who is not registered, or a non-registered longshore worker employed to perform container maintenance and repair work under the terms of the Pacific Coast Longshore Contract Document for an employer which is a party to the Pacific Coast Longshore and Clerks' Agreement, and Welfare Plan contributions are being paid on your behalf as provided under the Welfare Agreement (including the employee contribution which is assessed for registered employees), you and your qualified dependents have Welfare Plan eligibility effective the first of the month following three months of continuous employment, and month to month thereafter while so employed. You have the same benefits as Active Employees, except where Registration is expressly a requirement for a particular benefit.

In addition, certain employees of the ILWU, the Benefit Plans Office, and ILWU locals, (as described in the Letter of Understanding between the parties dated August 13, 1997), also have eligibility while so employed.

HIPAA Special Enrollment Rights

You may revoke an election with respect to medical coverage during the Plan Year and make a new election that corresponds with the special enrollment rights that were added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and permit mid-year enrollment for you and your Spouse and Dependent Children in certain circumstances.

If you decline enrollment for yourself and/or your Spouse or Dependent Children because of other health insurance coverage, you may in the future be able to enroll yourself and/or your Spouse or Dependent Children in the Welfare Plan, or change health care plan options, provided that you request enrollment within 30 days after the other coverage for you and/or your Spouse and/or Dependent Children ends if such other coverage was lost due to:

- The loss of eligibility for such other coverage;
- The cessation of employer contributions for such other coverage; or
- The exhaustion of COBRA coverage.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, or change health care plan options, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you or your dependents were covered under a Medicaid plan under Title XIX of the Social Security Act or under a State Children's Health Insurance Program (CHIP) and you (or your dependent's) coverage is terminated as a result of loss of eligibility for such coverage or you (or your dependent) become eligible for premium assistance with respect to coverage under the Welfare Plan under a Medicaid plan or CHIP, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days after the occurrence of such events. Contact the Benefit Plans Office for the appropriate enrollment form.

B

Qualified Medical Child Support Orders

The Welfare Plan also provides coverage for a Participant's Dependent Child under the terms of a Qualified Medical Child Support Order (QMCSO).

A QMCSO is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or a National Medical Support Order (as defined by section 609(a)(5)(C) of ERISA). The QMCSO may not require the Welfare Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan. In order for a Medical Child Support Order to be qualified, the child or children for whom it requires coverage must satisfy the age requirements for Dependent Child coverage as defined on page 37, but such children may not need to satisfy all of the other criteria for Dependent Child coverage set forth in that definition.

When you receive any documentation regarding a QMCSO, please provide such documentation to the Benefit Plans Office immediately upon issuance. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. The Benefit Plans Office will determine whether or not an order mandating coverage for a Dependent Child is "qualified" as a QMCSO. The Benefit Plans Office follows certain procedures to make this determination, and will notify you if it determines that an order is qualified. You may receive a copy of these procedures at no charge from the Benefit Plans Office.

Section C:

Special Eligibility Rule for Newly Registered Employees

If you are a newly registered employee, you and your dependents will, on the first day of the month following registration (with no requirement for 400 hours of work for initial eligibility for coverage), be eligible for Welfare Plan coverage for the first 24 months of registration. If you are assigned to a Choice Port, you will be enrolled in the applicable HMO during such 24-month period. After 24 months of eligibility, normal Welfare Plan eligibility requirements apply. (See Page 5 [How Eligibility for Plan Benefits is Determined for Active Employees].)

If you are a newly registered employee assigned to a Non-Choice Port, you and your dependents will, on the first day of the month following registration (with no requirement for 400 hours of work for initial eligibility for coverage), be eligible for Welfare Plan coverage and will be enrolled in the ILWU-PMA Coastwise Indemnity Plan (Coastwise Indemnity Plan) for the first 24 months of registration. After 24 months of eligibility, normal Welfare Plan eligibility requirements apply. (See Page 5 [How Eligibility for Plan Benefits is Determined for Active Employees].)

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Section D:

Loss of Eligibility

Your Welfare Plan eligibility will end upon the earlier of (1) your death, (2) the termination of the Welfare Plan (as discussed in paragraph 10 of "General Information" on page 34), (3) the amendment of the Welfare Plan in a manner that renders you ineligible (as discussed in paragraph 11 of "General Information" on page 34), (4) in certain instances, a violation of either the following certification: "I understand that if I misstate or misrepresent any information on an enrollment form, my dependents and I may each lose eligibility for benefits under the ILWU-PMA Welfare Plan" or the agreement to reimburse the Welfare Plan for benefit payments recovered from an employer or third-party; (5) at the discretion of the Trustees if you furnish incorrect or incomplete information in order to qualify for eligibility or benefits, avoid paying all or a portion of an applicable copayment or deductible by reason of an assigned reimbursement claim that misstates the amount actually charged by a provider of services, or otherwise mistakenly receive benefits; or (6) the occurrence of any of the following events:

Active Employees:

- the effective date of an Annual Review if the hours requirement for eligibility is not satisfied;
- severance from the industry;
- retirement (except that an Active Employee who loses eligibility upon severance from the industry due to retirement establishes eligibility as a Pensioner if qualified);
- loss of registration;
- the 91st day of an authorized Leave of Absence for any reason other than a disability illness or injury (or as otherwise required by USERRA);
- commencement of an authorized Leave of Absence for military service or to work as a superintendent;
- for certain employees of the ILWU, the Benefit Plans Office, and ILWU locals, (as described in the Letter of Understanding between the parties dated August 13, 1997), the end of the month in which their covered employment terminates;
- failure of employer to make required contributions to the Welfare Plan; or
- for CFS and Maintenance and Repair steady employees and nonregistered longshore workers employed to perform container maintenance and repair work, the end of the month in which they are laid off or otherwise leave employment.

Dependent Spouses:

- enrollment cancelled by person through whom enrolled;
- loss of eligibility by person through whom enrolled;
- final dissolution of marriage;
- failure to maintain enrollment in Medicare Part B when required.

Dependent Children:

- enrollment cancelled by person through whom enrolled;
- loss of eligibility by person through whom enrolled;
- attainment of age limit for dependent coverage (see definition of Dependent Child on page 37);
- end of dependency upon person through whom enrolled;
- failure to maintain enrollment in Medicare Part B when required;
- for Dependent Children whose Welfare Plan coverage is taxable to the Participant, Participant's failure to pay required withholdings for taxes due on coverage as requested by the Benefit Plans Office.

Pensioners:

- cease to be a Pensioner;
- failure to maintain enrollment in Medicare Part B when required.

Surviving Dependent Spouses of Deceased Actives with Fewer than 5 Years of Vested Service Under Either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan:

- remarriage;
- failure to maintain enrollment in Medicare Part B when required;
- the expiration of the 4-year period after the Active Employee's death, unless electing continuation coverage (see page 1).

Surviving Dependent Children of Deceased Actives with Fewer than 5 Years of Vested Service Under Either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan:

- attainment of age limit for dependent coverage (see definition of Dependent Child on page 37);
- failure to pay premiums when required;
- failure to maintain enrollment in Medicare Part B when required;
- the date a Surviving Dependent Spouse claiming through the same longshore worker loses eligibility;
- the expiration of the 4-year period after the Active Employee's death, unless electing continuation coverage (see page 1).

Adult Dependent Spouse Survivors of Deceased Pensioners or Active Employees with at Least 5 Years of Vested Service Under Either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan:

- remarriage;
- failure to maintain enrollment in Medicare Part B when required.

Dependent Child Survivors of Deceased Pensioners or Active Employees with at Least 5 Years of Vested Service Under Either the ILWU-PMA Pension Plan or the ILWU-PMA Watchmen Pension Plan:

- termination of survivor pension benefits;
- attainment of age limit for dependent coverage (see definition of Dependent Child on page 37);
- failure to maintain enrollment in Medicare Part B when required.

Surviving ERISA Spouse:

- remarriage;
- failure to maintain enrollment in Medicare Part B when required.

Confinement in a Public Institution

Welfare Plan health care benefits will terminate for an otherwise eligible person immediately upon confinement in a public institution (other than a Veterans Administration or other military hospital) where room, board, and medical care are provided.

Upon loss of eligibility no person may qualify to receive Welfare Plan benefits, except as provided under "COBRA" below.

Re-establishing Eligibility

If you are an eligible Active Employee who is granted a Leave of Absence that terminates your Welfare Plan eligibility, and you return from your Leave during a period for which you had established eligibility, your eligibility will be re-established immediately. Otherwise, you will re-establish eligibility only by working, or being otherwise credited with (except for disability credits), hours sufficient to satisfy the hours requirement as set forth in the Annual Review and Mid-Year Review discussion (see page 5).

If you are an eligible Active Employee and are granted a Leave of Absence to work as a superintendent, your eligibility will be re-established as of the date you return from your Leave and will continue until you first have an opportunity to establish eligibility by meeting the hours requirement, provided you return to covered employment within 30 days following the end of your Leave of Absence.

If you are an Active Employee who exhausts the five-year-maximum period of eligibility on account of continuous disability credits, as described on page 6, you will re-establish eligibility only by working, or being otherwise credited with (except for disability credits), hours sufficient to satisfy the hours requirement as set forth in the Annual Review and Mid-Year Review discussion (see page 5).

If you lose Welfare Plan eligibility because of failure to maintain enrollment in Medicare Part B when required, you will re-establish eligibility upon proof of such enrollment.

If your Dependent Spouse or Dependent Child loses Welfare Plan eligibility because you fail to pay withholdings for taxes on their coverage as required by the Benefit Plans Office, their eligibility will be re-established in the first calendar quarter beginning at least six weeks after all such requested withholdings have been paid.

COBRA - Continuation of Medical Coverage

Persons who lose Welfare Plan eligibility as described above will be informed by the Benefit Plans Office if they are entitled to COBRA continuation coverage.

COBRA is the abbreviated name of a federal law, the Consolidated Omnibus Budget Reconciliation Act. COBRA requires that the Trustees of the Welfare Plan offer Participants and family members the opportunity for a temporary extension of certain medical benefits under the Welfare Plan, called "continuation coverage", following the occurrence of certain "qualifying events" (as defined below), where coverage would otherwise end.

COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose medical coverage under the Welfare Plan because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must self-pay

for it. The cost is the same as the cost to the Plan for this coverage, plus a 2% administrative fee. If, however, a qualified beneficiary is determined to be disabled under the Social Security Act and qualifies for the disability extension described below, the cost for COBRA continuation coverage, including administrative charges, increases to 150% of the applicable premium.

Qualifying Events

If you are an Active Employee covered by the Welfare Plan, you will become a qualified beneficiary if you lose medical coverage because during an Annual Review you are found to have insufficient hours to continue eligibility or if you are deregistered or otherwise terminate employment for any reason (including retirement without Welfare Plan eligibility) other than for gross misconduct.

The Dependent Spouse of an Active Employee covered by the Welfare Plan will become a qualified beneficiary if he or she loses medical coverage for any of the following reasons:

1) The Active Employee's loss of coverage because of insufficient hours to continue eligibility, deregistration, or other termination of employment for any reason (including retirement without Welfare Plan eligibility) other than gross misconduct;
2) Divorce or legal separation from the Active Employee; or
3) Death of the Active Employee (unless the Dependent Spouse is otherwise entitled to continued eligibility under the Welfare Plan).

A Dependent Child who is covered by the Welfare Plan will become a qualified beneficiary if he or she loses medical coverage for any of the following reasons:

1) The Active Employee's loss of coverage because of insufficient hours to continue eligibility, deregistration, or other termination of employment for any reason (including retirement without Welfare Plan eligibility) other than gross misconduct;
2) Parents' divorce or legal separation resulting in loss of dependent status (if the divorce results in a loss of coverage under the Welfare Plan for the Dependent Child);
3) Death of a parent (unless the child is otherwise entitled to continued eligibility under the Welfare Plan); or
4) Ceasing to be a Dependent Child as defined in the Welfare Plan (see definition of Dependent Child on page 37).

The Welfare Plan will offer COBRA continuation coverage to qualified beneficiaries after the Benefit Plans Office has been notified that a qualifying event has occurred. Under COBRA law, the employee or a family member must inform the Benefit Plans Office of a divorce, legal separation, or a child losing dependent status under the Welfare Plan within 60 days of the event. Forms that may be used for this purpose are available at the ILWU locals and the Benefit Plans Office. If you fail to notify the Benefit Plans Office within the applicable time period, you and your dependents will lose the right to elect COBRA continuation coverage.

Once the Benefit Plans Office is notified that one of these events has occurred, it will notify qualified beneficiaries of the right to choose COBRA continuation coverage within 30 days from the date the Benefit Plans Office is notified of the qualifying event. Qualified beneficiaries have 60 days from the later of the date of the notification or the date the qualified beneficiary would lose coverage because of one of the events described above to elect and pay for COBRA coverage. If some or all of the qualified beneficiaries do not choose COBRA coverage on a timely basis, their coverage under the Plan will end. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost and payment for coverage must be made for the same period. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is divorce or legal separation or a Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the employee's insufficient hours or deregistration, the COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage – If any qualified beneficiary covered under the Welfare Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and he or she notifies the Benefit Plans Office in a timely fashion, the qualified beneficiary and his or her entire family can receive up to an additional 11 months of COBRA, for a total of 29 months. The Benefit Plans Office must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the original 18-month period of COBRA continuation coverage. The affected individual must also notify the Benefit Plans Office within 30 days of any final determination that the individual is no longer disabled. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Second qualifying event extension of 18-month period of continuation coverage – If a second qualifying event occurs while a family is receiving COBRA continuation coverage that results in a loss of coverage under the Welfare Plan, the Dependent Spouse and Dependent Children in the family may be eligible for additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the Dependent Spouse and Dependent Children, if the former employee dies or gets divorced or legally separated. The extension is also available to a Dependent Child who stops being eligible under the Welfare Plan as a Dependent Child.

A brochure about COBRA has also been furnished to ILWU locals and is available without cost and upon request from the Benefit Plans Office.

USERRA

Eligible employees who go on military leave may have a separate right under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), 38 U.S.C. Section 4317, to continue medical, surgical, prescription drug, dental, and vision care benefits under the Welfare Plan at 100% of the cost to the Plan of group coverage (plus a 2% administrative fee) for up to 24 months starting on the day the eligible employee's military leave of absence begins.

"Uniformed Service" means the performance of active duty in the uniformed services under competent authority. It includes training, full-time National Guard duty, and the time needed for an examination to determine the participant's fitness for duty.

If you believe you are entitled to continuation of Welfare Plan coverage pursuant to USERRA, you should notify the Benefit Plans Office. You should provide the notice at least 30 days before the start of your leave, unless it is unreasonable or impossible for you to do so because of reasons such as military necessity.

Continuation of Welfare Plan Coverage While on Military Leave

If you do not provide advance notice of your leave and do not elect continued Welfare Plan coverage prior to the leave, coverage for you and your dependents will terminate on the date you would otherwise become ineligible. However, if you are excused from giving advance notice because it was unreasonable or impossible for you to provide advance notice because of reasons such as military necessity, coverage will be retroactively reinstated if you elect coverage for yourself and your dependents and pay all unpaid premiums for the period since you became ineligible.

If you provide advance notice of your leave but do not elect continued coverage before your leave, coverage for you and your dependents will terminate on the date you would otherwise become ineligible. However, coverage will be reinstated if you elect continued coverage at any time during your leave and you pay all unpaid premiums for the period since you became ineligible.

If you elect continued coverage but do not make timely payments for the cost of coverage, then coverage for you and your covered dependents will terminate at the end of the period for which you have paid premiums.

The maximum period of continued coverage for you and your dependents is 24 months after the date on which you would otherwise have become ineligible. Note that if you are entitled to COBRA coverage, the COBRA continuation coverage period runs concurrently with the USERRA coverage period. In some instances, COBRA coverage may continue longer than the USERRA coverage period.

Eligibility for Welfare Plan Coverage upon Returning from Military Leave

If an Active Employee, as of the commencement date of his or her said military leave of absence, then had Welfare Plan eligibility, such Active Employee shall be immediately eligible for Welfare Plan benefits if he or she returns promptly to work following his or her discharge from the military service as provided by the laws of the United States.

If an Active Employee who is not a Registered Longshore Worker, Marine Clerk, Walking Boss/Foreman or Watchman (Registered Active Employee), as of the commencement date of his or her said military leave of absence, did not then have eligibility for Welfare Plan benefits, such Active Employee shall be eligible for Welfare Plan benefits if he or she re-establishes eligibility by working or otherwise being credited hours. See page 13 under Re-establishing Eligibility.

If a Registered Active Employee as of the commencement date of his or her military leave of absence did not then have eligibility for Welfare Plan benefits, such Registered Active Employee shall be eligible for Welfare Plan benefits if hours credited to such Registered Active Employee for his or her military service when combined with hours worked or otherwise credited, are sufficient to establish his or her eligibility under either paragraph 2.11 or 2.12 of the Welfare Agreement, and such eligibility shall be effective as of the first day of the month following his or her discharge from the military service and his or her prompt return to work under a collective bargaining agreement recognized under the Welfare Agreement as provided by the laws of the United States. Said credit shall be in an amount equal to the hours credits as determined by the CLRC in accordance with the terms and conditions of the CLRC Agreement on USERRA.

Eligibility established under the Plan shall continue until the Trustees, in their sole, absolute, and unreviewable discretion, determine that sufficient time has elapsed following said Active Employee's return to work to enable him or her to accumulate sufficient hours to become eligible for Welfare Plan benefits, and an Active Employee shall thereafter have eligibility only if he or she has accumulated sufficient hours under the terms of the Welfare Plan.

Section E:

ILWU-PMA Welfare Plan Benefit Programs

Detailed descriptions of benefits and services provided under each Welfare Plan benefit program are available in separate Supplemental Summary Plan Description booklets and are incorporated by reference herein. The booklets describe how and where to obtain benefits, any additional requirements other than Welfare Plan eligibility that must be met to be entitled to a particular benefit, whether dependent coverage is provided and, if so, the qualifications, and information about claims and review procedures. To the extent a Supplemental Summary Plan Description or this booklet is inconsistent with the Welfare Agreement, the provisions of the Welfare Agreement will govern.

Copies of Supplemental Summary Plan Description booklets are supplied to ILWU locals and are available without cost upon request at the Benefit Plans Office.

The Plan does not provide any person with benefits (other than Death, Accidental Death and Accidental Dismemberment benefits) for conditions that are covered by the Longshoremen's and Harbor Workers' Compensation Act and/or a state workers' compensation or similar act that provides compensation for industrial injury.

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Section F:

Health Care Programs

The health care programs of the Welfare Plan provide hospital-medical-surgical benefits, prescription drugs, vision care, and dental care. If your Assigned Port is a Choice Port or Choice Area, and you are Welfare Plan eligible, your Welfare Plan health care programs are provided by either an HMO or through a primarily self-funded arrangement, the Coastwise Indemnity Plan. You may choose between the HMO and the Coastwise Indemnity Plan during the annual open enrollment period and at one other time during the Plan Year.

If you are a newly registered longshore worker assigned to a Choice Port, you and your dependents will, on the first day of the month following registration (with no requirement for 400 hours of work for initial eligibility for coverage), be covered by an HMO program for the first 24 months of registration. After 24 months of registration, you will have a choice between HMO or Coastwise Indemnity Plan coverage and normal Welfare Plan eligibility requirements will apply.

The Trustees of the Welfare Plan may provide on an "exception basis" that a person eligible for HMO coverage under this provision may be provided limited coverage under the Coastwise Indemnity Plan specific to any serious health condition for which they are receiving treatment when Welfare Plan coverage begins.

If you are a newly registered longshore worker assigned to a Non-Choice Port or Non-Choice Area, and you are Welfare Plan eligible, your Welfare Plan coverage is available to you primarily through the Coastwise Indemnity Plan. Non-Choice Port Participants will have PPO access (at PPO reimbursement levels where the provider is a PPO provider and 100% of MAC for non-PPO providers).

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Section G:

Claims Review Procedures

Claims for benefits under any individual benefit program provided under the Plan should be submitted directly to the insurance carrier, provider of care, or third party administrator, as directed in the Supplemental Summary Plan Description booklet that describes the particular benefit, and will be handled in accordance with the procedures described in the Supplemental Summary Plan Description booklet. For instance, claims for medical benefits under the Coastwise Indemnity Plan or under an HMO will be handled in accordance with the claims review procedures contained in the Supplemental Summary Plan Description for the Coastwise Indemnity Plan or the certificates/materials separately provided by the HMO provider, as applicable.

All appeals from denials of claims for benefits (such as claims for Welfare Plan eligibility or for disability and other credits toward the hours requirement for Plan eligibility) that do not arise under a Supplemental Summary Plan Description and are denied or partly denied will be reviewed in accordance with the claims review procedures outlined below. Please note that a mere inquiry about whether a particular item is covered under the Plan is not a claim for this purpose.

NOTE: In the event two or more beneficiaries present competing claims for the same benefits or eligibility status, the Trustees may, in their sole discretion, file an interpleader action in the appropriate court to resolve the matter. An interpleader action is a court action in which the Trustees will pay the subject benefits to the court and the court will decide which party or parties will receive the benefits.

Claim Denial

If a claim is denied or partly denied, notice will be given to the claimant in writing. The notice will be written in understandable language, and will state:

1. Information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount;
2. Specific reasons for denial of the claim;
3. Specific reference to provisions of the Welfare Agreement or contract provisions upon which the denial is based;
4. A description, if appropriate, of additional information or material which might enable the claimant to perfect the claim and an explanation of why the requested information or material is necessary;
5. An explanation of how, where, and when the claimant may obtain a review of the denial and the applicable time limits;
6. A statement of the claimant's right to bring legal action under ERISA;
7. If the denial is based on an internal rule, guideline, or protocol, that the claimant has the right to request a free copy of the rule, guideline, or protocol; and
8. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, the claimant has the right to request a free copy of the scientific or clinical judgment on which such denial is based.
9. In the case of a claim involving disability, the written determination will also include a discussion of the decision including an explanation of the basis for disagreeing with or not following: (i) the views presented to the Plan of health care professionals treating you or vocational professionals who evaluated you; (ii) the views of the medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and (iii) the Social Security Administration disability determination presented by you to the Plan.

Timing of Claim Response

In general, except with respect to medical and disability claims, if a claim is wholly or partially denied, the plan administrator shall notify the claimant (in accordance with the parameters in the Claim Denial section on page 21), of the Plan's denial within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

With respect to medical claims, notice of a claim denial must be given to the claimant within a reasonable time, but no later than 30 days after the date the claim is received. This period may be extended an additional 15 days if special circumstances require an extension of time and the Benefit Plans Office notifies the claimant before the end of the initial 30-day period of the extension and the date by which the Benefit Plans Office expects to render a decision on the claim. If an extension is required because the claimant failed to provide sufficient information to allow the Benefit Plans Office to make a determination on the claim, the notice of extension will describe the additional information required, the claimant will be given at least 45 days to provide the additional information, and the period from the date the claimant is notified of the additional information to the date the claimant responds is not counted as part of the determination period.

In the case of the denial of a claim for Weekly Indemnity, CSDI Supplementation or Non-Industrial Disability Supplement benefits, notice of the denial will be provided to the claimant no later than 45 days after the date the claim is received. This period may be extended an additional 30 days if the Benefit Plans Office determines that an extension is necessary due to matters beyond its control and the claimant is notified of the extension before the end of the initial 45-day period and the date by which the Benefit Plans Office expects to render a decision on the claim. The notice of extension shall specify any additional information that the Benefit Plans Office may need from the claimant in order to make a decision on the claim. The period may also be extended for an additional 30-day period if the Benefit Plans Office is unable to make a determination within the original extended period. If an extension is required because the claimant failed to provide sufficient information to allow the Benefit Plans Office to make a determination on the claim, the claimant will be given at least 45 days to provide the additional required information. The period from the date the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

If the Benefit Plans Office does not respond to the claimant's claim within the time periods specified above, the claimant may deem his or her claim denied for this purpose as of the expiration of the applicable time period above.

NOTE: In the event the claimant fails or refuses to cooperate with the Benefit Plans Office in obtaining documents or other information necessary to allow the Benefit Plans Office to decide a claim, the Benefit Plans Office may deny the claim on the ground of non-cooperation.

Request for Claim Review

With dates of service on or after January 1, 2013, the timing of when to appeal a claim denial to the Trustees depends on the type of claim appealed. For medical and disability claims, the claimant must appeal the claims denial within 1 year after the claimant receives notice of the claim denial or after the claim is deemed denied as provided on the previous page. For all other claim denials, including eligibility, the claimant must request a claim review within 60 days after the claimant receives notice of the claim denial or after the claim is deemed denied as provided on the previous page. The claimant or his/her authorized representative may request copies free of charge, of all documents, records or other information relevant to this claim. This includes documents relied on in making the benefit determination or submitted or generated in the course of the review.

Requests for a review by the Trustees should be submitted to:

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109

When making your request for a claim review, you should submit it to the ILWU-PMA Benefit Plans in writing and describe the reasons for the appeal. Along with your written appeal, you may, but need not, submit additional documentation, issues and comments for the Trustees to consider during their review of your denied claim.

If you or your representatives request, the Benefit Plans Office will provide reasonable access to and copies of all documents, records, and other information on your claim, free of charge, including:

1. information relied upon in making the denial;
2. information submitted, considered or generated during the denial decision, whether or not it was used in making the decision;
3. Records of any independent reviews conducted by the Coastwise Claims Office; and
4. Expert advice and consultation obtained by the Coastwise Claims Office in connection with the denial decision, if any.

Decision by Trustees

The Trustees, or a committee of the Trustees, will render their decision on a Weekly Indemnity, CSDI Supplementation or Non-Industrial Disability Supplement benefit claim within 45 days of receipt of the request for review.

With respect to any other type of claim under the Plan, the Trustees, or a committee of the Trustees, will render their decision on the claim within a reasonable period but no later than 30 days following the receipt of the claimant's request for review. This 30-day period may be extended for up to an additional 30 days if the Trustees determine that an extension is necessary and if the claimant is notified prior to the expiration of the initial 30-day period and provided the date by which the Trustees expect to render a decision.

If, following Trustee review, a claim is denied or partly denied, notice will be given to the claimant in writing. The notice will be written in understandable language, and will state:

1. Specific reason or reasons for upholding in part or in full the denial of the claim;
2. Specific reference to provisions of the Welfare Agreement or to contract provisions upon which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. A statement describing the Plan's appeal procedures and the claimant's right to obtain the information about such procedures from the Benefit Plans Office, and a statement of the claimant's right to bring an action under ERISA;
5. If the decision was based on an internal rule, guideline, or protocol, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial will be provided free of charge upon request;
6. If the decision was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. A statement that "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."
8. Additionally, in the case of an appeal of a disability denial, the written determination will also include a discussion of the decision including an explanation of the basis for disagreeing with or not following: (i) the views presented to the Plan of health care professionals treating the claimant or vocational professionals who evaluated the claimant; (ii) the views of the medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and (iii) the Social Security Administration disability determination presented by the claimant to the Plan.

If the Trustees do not respond to the claimant's request for review within the time periods specified above, the claimant may deem his or her claim denied on review for this purpose as of the expiration of the applicable time period above.

Request for Arbitration

Within 180 days after the claimant receives notice that a claim has been denied or partly denied by the Trustees on review, or if the claim is deemed denied on review as provided above, the claimant or his/her authorized representative may make a written request for review by the Coast Arbitrator. In order to obtain review of a claim denial by the Coast Arbitrator, the claimant must have obtained a prior determination on the claim by the Trustees (or a deemed denial) in accordance with the procedures outlined above. The claimant or his/her authorized representative may request copies, free of charge, of all documents, records and other information relevant to the claim. This includes documents relied on in making the benefit determination or submitted or generated in the course of the review.

A request for review by the Coast Arbitrator must be submitted to:

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109

Decision by Coast Arbitrator

The Coast Arbitrator will render a decision on the claim within 30 days following receipt of the claimant's request for arbitration, except for claims for Weekly Indemnity, CSDI Supplementation or Non-Industrial Disability Supplement benefit claims. For Weekly Indemnity, CSDI Supplementation or Non-Industrial Disability Supplement benefit claims, the Coast Arbitrator will render a decision within 45 days following receipt of the claimant's request for arbitration. The time period for completion of arbitration may be extended at the request and approval of the claimant, if for example the claimant wishes to submit a brief or desires that an authorized representative submit a brief on his or her behalf. The time period may also be reasonably extended if the claimant submits new evidence in support of the claim that was not considered by the Trustees during their review.

The decision of the Coast Arbitrator will be communicated to the claimant in writing, and in understandable language. If it sustains the denial, it will include specifically: (A) specific reasons for the decision; (B) specific references to the pertinent provisions of the Plan or contract or policy of insurance purchased by the Trustees to provide benefits on which the decision is based; (C) a statement that the claimant is entitled to receive, upon request and free of charge, all documents, records, and other information relevant to the claim; (D) a statement of the claimant's right to bring an action under ERISA; (E) if the denial relates to a claim for disability benefits (or to a claim for medical benefits on or after July 1, 2002) and is based on an internal rule, guideline, or protocol, a copy of the internal rule, guideline, or protocol, or a statement that a copy will be provided free of charge upon the claimant's request; and (F) if the denial relates to a claim for disability benefits (or to a claim for medical benefits on or after July 1, 2002) and is based on medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon the claimant's request. Additionally, in the appeal of a disability denial, the written determination will also include a discussion of the decision including an explanation of the basis for disagreeing with or not following: (i) the views presented to the Plan of health care professionals treating the claimant or vocational professionals who evaluated the claimant; (ii) the views of the medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and (iii) the Social Security Administration disability determination presented by the claimant to the Plan.

Judicial Review

A claimant has the right to file a suit in a court of law if a claim is denied or partly denied on appeal by the Coast Arbitrator. Plan provisions and applicable law require, however, that the claimant first exhaust all of his or her appeal rights under the Plan. This means that a claimant must obtain determinations by the Trustees and by the Coast Arbitrator before he or she may file a lawsuit for a benefit under the Plan.

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Section H:

Privacy of Health Information

The receipt, use and disclosure of Protected Health Information (PHI) by the Welfare Plan are governed by regulations issued under the Health Insurance Portability and Accountability Act (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH).

In accordance with these regulations, the administrator of the Welfare Plan, certain employees of the Welfare Plan and the Welfare Plan's business associates may receive, use and disclose PHI in order to carry out payment, treatment, and health care operations under the Welfare Plan. These entities and individuals may use PHI for such purposes without consent or written authorization.

In addition, PHI may be shared without consent or written authorization for administrative purposes. In the normal course, if an individual's PHI is used or disclosed for any other purpose, that individual's written authorization for such use or disclosure will be required.

The Benefit Plans Office will send to all Participants a Notice of Privacy Practices that (i) describes certain rights, which Participants have with regard to PHI; and (ii) explains the Welfare Plan's obligation to protect such health information. PHI includes genetic information (such as family medical history and information about an individual's receipt of genetic services or genetic tests). However, in accordance with federal law, the Plan does not intend to use or disclose genetic information for underwriting purposes.

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Section I:

Subrogation and Reimbursement

Subrogation and Reimbursement

The Welfare Plan will pay benefits for an injury or illness for which a third party may be liable only on the condition that the covered person, or the legal representative of the covered person, completes an "Agreement to Reimburse Benefits" form. This is an agreement to reimburse the ILWU-PMA Welfare Plan for any Welfare Plan benefits paid on account of an injury or illness, to the extent benefits or other compensation are received for the same injury or illness under Workers' Compensation laws or from any third party.

Any person who has received, is receiving, or is eligible to receive benefits under the Welfare Plan agrees (1) to reimburse the Plan the portion it is due for benefits paid on account of any illness, injury, or condition for which an employer or other third party (or their respective insurers) may be liable, regardless of whether such recovery is less than the actual loss suffered by the person, from the proceeds of any judgment, settlement, payment or otherwise, and irrespective of whether responsibility is accepted or denied by an employer or other third party; (2) to waive any argument or contention that any action by the Trustees in state court is pre-empted by federal law; and (3) to assign to the Trustees the person's right of action against the employer or other third party (or their respective insurers) to the extent benefits have been paid or may be paid in the future. In addition, any person eligible for benefits must, in order to receive any benefits and to maintain eligibility under the Plan, (i) notify the Trustees of the Plan within thirty (30) days after making a claim against an employer or other third party (or their respective insurers) relating to an incident leading to damages, benefits and/or other compensation, of the fact and nature of such claim; (ii) furnish any information or assistance and execute any documents that the Trustees may require; and (iii) take no action that may prejudice or interfere with such rights.

Whether or not the preceding requirements are satisfied, the Trustees shall (1) be automatically assigned such person's right of action against the employer or other third party (or their respective insurers) to recover benefits that have been paid or may be paid in the future; (2) have the right to intervene at any time in any action brought against an employer or other third party (or their respective insurers) to recover all benefits that have been paid or may be paid in the future; (3) be reimbursed fully from the proceeds of any judgment, settlement, payment or other resolution of any action or proceeding, including from the estate of any covered person, to recover benefits that have been paid or may be paid in the future, regardless of whether the total amount of such recovery is less than the actual loss suffered by the person; (4) be reimbursed 100% of the charges the Plan paid in a lump sum at the time payment is received by a covered person, his or her dependents, or his or her representative; and (5) have an automatic first lien upon any recovery to the extent of benefits that have been paid or in the future may be paid. In all five instances set forth above in this paragraph, the Trustees shall have such rights regardless of whether the total amount of such recovery is less than the actual loss suffered by the person. The Trustees shall also be fully reimbursed for any charges paid in error, whether the error was that of the Plan, participant, or dependent.

If any person does not comply with any of the foregoing requirements, the Trustees may suspend that person's ongoing eligibility for benefits and deny pending or future claims until such time that he or she is in compliance with such requirements. Specifically, if any participant or dependent enters into any settlement of his/her claim(s) pursuant to the Longshore and Harbor Workers' Compensation Act and/or state workers' compensation law or personal injury law (whether or not a lawsuit is filed) that does not include complete and final resolution of the Plan's lien, claim for reimbursement and/or subrogation claim immediately upon effectuation of such settlement, the Plan may suspend the person's ongoing eligibility for benefits and deny pending or future claims until the Plan has recouped an amount equal to the value of such claims. Such recoupment may be accomplished via processing of weekly indemnity and/or medical benefit claims without any issuance to such person of payment(s) of the amounts normally payable under the Plan.

The Plan expressly disavows the application of legal theories such as the "collateral source rule", the "make-whole" doctrine and the "common fund" doctrine to the extent that they may prevent or limit the Welfare Plan's recovery from any payment a person with eligibility receives from a third party (or its insurer). The Plan's reimbursement will not be reduced to pay any portion of the attorneys' fees and costs associated with the person's legal recovery. The Plan's cost of collection would be part of the Plan's subrogation claim in instances when the Plan pursues collection of reimbursable amounts.

The information in this section applies to any no-fault insurance recoveries and to all other proceedings and actions, including but not limited to proceedings under the Longshore and Harbor Workers' Compensation Act, other workers' compensation acts, and actions for negligence, medical malpractice, products liability, and other torts or wrongful acts.

Section J:

Overpayment of Benefits and Assignment

The Trustees of the Plan, or their representatives, may, in their sole, absolute, and unreviewable discretion, require repayment of any overpaid amount directly from a provider of service and/or a beneficiary, through collection proceedings and/or by offset of any overpaid amount against other Benefits payable by the Plan, under the following circumstances:

1. If the Plan issues reimbursement payments through error, misrepresentations, or fraud to a provider of service, or to a beneficiary, which exceeds the allowed amount under the Plan; or
2. If a beneficiary is paid any money, or receives anything of other than nominal value, from a provider of service and a reimbursement claim is made that misstates the amount actually charged by the provider of service.

The Trustees may collect the amount of any such overpayment(s) and any amounts expended or incurred in investigating the matter and collecting the overpayment(s), including, but not limited to, expenses of the Trustees' staff and reasonable fees of any investigators, attorneys and/or consultants retained by or on behalf of the Trustees. If a provider of service fails to collect all or a portion of an applicable copayment or deductible from a beneficiary, resulting in a reimbursement claim that misstates the amount actually charged by the provider of service, the Trustees may require repayment of any amounts the Plan paid to the provider. The Trustees may also, in their sole, absolute and unreviewable discretion, suspend Eligibility or Benefits with respect to such person found to have furnished incorrect or incomplete information in order to qualify for Eligibility or Benefits, and take any other action they may deem necessary or appropriate under the circumstances. Nothing in this section limits any rights that the Trustees or the Plan may have to recover any amounts allowed by law.

Assignment

Under provisions of the Welfare Plan, Welfare Plan benefits are not subject to assignment by a participant, beneficiary or any other person except the Trustees, and any attempt to do so shall be void. However, ERISA provides that in the case of persons with coverage under a State Medicaid program, automatic assignment of benefits to State Medicaid agencies is enforceable against the Plan. Generally, Welfare Plan benefits or the rights to receive such benefits may not be assigned to any third-party, other than (to the extent required by federal law) to State Medicaid agencies. The Welfare Trustees do permit, however, a participant or beneficiary to request that benefits otherwise payable under the Welfare Plan be paid directly to a service provider on behalf of the participant or beneficiary. The Benefit Plans Office will generally accommodate such requests when they are in writing. Where benefits are paid directly to a doctor, hospital or other provider of care (other than to a State Medicaid agency), such direct payments are provided at the discretion of the Trustees as a convenience to Plan Participants. However, because the Welfare Agreement does not accept "assignments" of benefit claims to service providers except as noted above, the Trustees reserve the right to refuse requests for direct payment, and a request for direct payment shall not be construed as an enforceable agreement. The participant or beneficiary remains primarily liable on any bill for which a request for direct payment has been made.

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Section K:

General Information

1. The Employer Identification Number issued to the ILWU-PMA Welfare Plan Trustees by the Internal Revenue Service is 94-6068578. The Plan Number assigned by the Trustees is 501. The Plan's fiscal year is July 1 through June 30.
2. The Trustees are the administrator of the Plan. The Trustees may designate employer and union Trustees having equal representation as a Benefit Subcommittee, which shall be the administrator of the Plan. The business address and business telephone number of the Plan administrator are those shown in this booklet for the ILWU-PMA Welfare Plan.
3. Service of legal process may be made upon a Plan Trustee or the administrator of the Plan. The person designated by the Plan as agent for the service of legal process is:

   Executive Director
   ILWU-PMA Benefit Plans
   1188 Franklin Street, Suite 101
   San Francisco, CA 94109

4. It is the Trustees' policy not to release information about a Plan Participant or beneficiary to anyone without either written authorization by the Participant or beneficiary or a court-ordered subpoena. A subpoena of records should be addressed to the "Custodian of Records" of the ILWU-PMA Welfare Plan.
5. The programs of the ILWU-PMA Welfare Plan are financed by contributions of employers and registered employees. Employers contribute to the Welfare Plan the amount in addition to employee contributions that is required to finance the programs and administrative costs of the Welfare Plan. Each registered employee, including Area Welfare Directors and ADRP representatives, contributes a percentage of his or her wages, excluding payments received under the ILWU-PMA Pay Guarantee Plans and the Welfare Plan. The employee contribution rate to the Welfare Plan is currently 1.1%, but is subject to change by agreement of the Trustees (each registered employee will be notified of any change). If an employee is required to contribute to the California State Disability Insurance program, his or her contribution to the Welfare Plan is reduced in the amount of his or her payment to that program.
6. Assets of the Welfare Plan are accumulated in the ILWU-PMA Welfare Fund and benefits are provided either under contracts or policies of insurance or by direct payment by the Welfare Plan. The Supplemental Summary Plan Description booklets identify the providers of benefits.
7. While this booklet and the Supplemental Summary Plan Description booklets set forth the terms and conditions of the contracts and policies of insurance between the Welfare Plan Trustees and the insurance carriers and providers of care, the provisions of such contracts and policies cannot be modified by the summaries set forth in this booklet and the Supplemental booklets. The terms and conditions of such contracts and policies of insurance, where applicable, control and limit availability of benefits under the Plan.
8. The Plan maintains a register which shows the names of persons currently serving in the office of Trustee, as a member of the Benefit Subcommittee, and as the Plan Executive Director. Beneficiaries and Participants may inspect the register, and upon written request may receive a copy of the names and business addresses of persons currently serving in any of the above mentioned capacities.
9. It is the Welfare Plan Trustees' policy to have the Benefit Plans Office give answers in writing to all questions about the Plan. By putting questions in writing, a Participant or beneficiary will be able to receive a written response to the exact question in mind. A Participant or beneficiary may rely upon written answers from the Benefit Plans Office. Conversely, a Participant or beneficiary should not rely on any oral answers to questions about the Plan from whatever source the oral information is received. A Participant or beneficiary should never assume that he or she can rely upon any statement as to his or her employment history, from whatever source, that he or she has the least reason to know to be inaccurate.

10. The Welfare Plan shall run concurrently with the Pacific Coast Longshore and Clerks' Agreement. Unless otherwise provided to the contrary, extension or renewal of said Pacific Coast Longshore and Clerks' Agreement shall extend the Welfare Plan and continue the Welfare Plan in effect for the period of such extension or renewal. If the Welfare Plan is not extended or renewed, any moneys in the ILWU-PMA Welfare Fund shall be used to pay benefits and administrative costs, as the Welfare Plan Trustees in their sole, absolute and unreviewable discretion determine to be appropriate. The Welfare Plan shall terminate when the ILWU-PMA Welfare Fund has been exhausted; provided that the Welfare Plan may be renewed thereafter by agreement of the ILWU and the PMA and the making of contributions in accordance with the Welfare Plan terms.

11. The ILWU and the PMA, by their mutual agreement in writing, may at any time amend, modify or delete any provisions of the Welfare Plan. This power specifically includes the authority to change, retroactively or prospectively, eligibility requirements and benefits provided under the Welfare Plan.

12. Participants and beneficiaries of the Welfare Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants and beneficiaries shall be entitled to:

    (a) Examine, without charge, at the Benefit Plans Office and at other locations designated by the Trustees all Plan documents governing the Plan, including contracts and policies of insurance with providers of care, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

    (b) Obtain, upon written request to the Benefit Plans Office, copies of all Plan documents and other Plan information governing the Plan, including information as to whether a particular employer is a contributing employer, insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Plan administrator may make a reasonable charge for copies.

    (c) Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

    (d) Continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. Persons continuing coverage may have to pay for such coverage. See COBRA on page 13.

In addition to creating rights for Plan Participants and beneficiaries, 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 interests of Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare Plan benefit or exercising your rights under ERISA.

If your claim for a Welfare Plan benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Your rights in this regard are explained on pages 22 to 25.

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.

Claimants may file suits in a state or federal court as referred to on page 26 of the Judicial Review section.

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

If you have any questions about your Plan, you should contact the Benefit Plans Office. 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, 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.

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Section L:

Some Helpful Definitions

Some of the terms used in this booklet are of special importance in understanding eligibility provisions and benefits described in its pages. The following definitions are based upon provisions of the ILWU-PMA Welfare Agreement.

Active Employee: A person who is a registered longshore worker under the Pacific Coast Longshore & Clerks' Agreement, a Walking Boss/Foreman under the Pacific Coast Walking Bosses & Foremen's Agreement, a Watchman under an agreement between ILWU Local 26 or Local 75 and the Pacific Maritime Association, or certain employees of the ILWU, the Benefit Plans Office, and ILWU locals, (as described in the Letter of Understanding between the parties dated August 13, 1997), while so employed.

Assigned Port: The port at which an Active Employee is registered, or such other port as a Joint Port Labor Relations Committee may determine to be his or her port of regular employment, or if he or she so elects, the port at which a registered Active Employee has been granted the status of being an official visitor by a Joint Port Labor Relations Committee. Pensioners and survivors shall have an Assigned Port determined by the Trustees on the basis of residence. Certain employees of the ILWU, the Benefit Plans Office, and ILWU locals, shall have an Assigned Port determined by the Trustees on the basis of work location. An eligible Active Employee whose registration is transferred to another port at the convenience of the industry and who does not change his or her place of residence may elect to retain the coverage of the port from which he or she is transferred.

Choice Port or Choice Area: A port or area for which the Trustees contract with a group practice health plan (HMO) serving such port or area with hospital-medical-surgical and other health care benefits and also provide insured and self-funded coverage for the same types of benefits. Eligible persons whose Assigned Port is a Choice Port or Choice Area may annually choose for themselves and their dependents between the HMO, and the insured and self-funded coverage, except that newly registered employees whose Assigned Port is a Choice Port or Choice Area will automatically have HMO coverage for the first 24 months of registration.

Clerks Working Opportunity Guarantee (CWOG) Program: The Clerks Working Opportunity Guarantee Program is a program designed to ensure that a registered Marine Clerk is provided full work opportunity as a Marine Clerk five out of seven days in any payroll week pursuant to the "Framework for Special Agreement on Application of Technologies and Preservation of Marine Clerk Jurisdiction, Item VI, November 23, 2002, Memorandum of Understanding."

Dependent Child: A person who:

1. is identified by an Active Employee or Pensioner on the form provided by the Trustees for the enrollment of dependents (which has been filed with the Trustees); and
2. is within one of the following classes:
   (a) a natural child of an Active Employee or Pensioner;
   (b) a legally adopted child of an Active Employee or Pensioner;
   (c) a stepchild or foster child of an Active Employee or Pensioner; or
   (d) a child who maintains a parent/child relationship with an Active Employee or Pensioner if such child's natural parent is not in fact supporting such child.

In addition to the above requirements, eligibility also requires that the dependent child

3. (a) has not attained 26 years of age; or
   (b) is, and continues to be, upon attaining age 26, mentally or physically incapacitated so as to be incapable of self-sustaining employment. See notes on the following page.

NOTES:

1. Washington and Oregon state insurance laws require group dental plans such as Dental Health Services Washington and Lifemap-Willamette Dental to extend coverage to dependents beyond age 19. Please contact the Benefit Plans Office at 415-673-8500 for further information regarding continued dependent eligibility under those plans.
2. Certain children for whom medical coverage is required to be provided under a Qualified Medical Child Support Order may not satisfy the definition of a Dependent Child in its entirety, but are required to satisfy the age requirement. See also QMCSO on page 8.
3. The Trustees will require a birth certificate or other documents to establish Dependent Child status.

Dependent Spouse: A person who is married to a Participant and who is so identified on both a valid marriage certificate and the form provided by the Trustees for the enrollment of dependents that has most recently been filed by the Active Employee or Pensioner with the Trustees. A person will be considered married if such marriage is valid under the laws of the state in which it was contracted.

Leave of Absence: A period during which an employee is granted permission by a Joint Port Labor Relations Committee to be absent from work or from availability for work.

Major Port: The Los Angeles/Long Beach Harbor Area, the San Francisco Bay Area, the Portland/Vancouver Area, the Seattle Area, the Tacoma Area, and any other port that is not classified as a Minor Port.

Minor Port: A port not named above as a Major Port, and for which the Annual Review by the Trustees shows the following: that of the registered employees assigned to the port who worked and/or received PGP credits for at least 100 hours during the review period, 25% or more worked or were so credited with less than 800 hours (or that, at the Mid-year Review, of the registered employees assigned to the port who worked and/or received PGP credits for at least 50 hours during the review period, 25% or more worked or were so credited with less than 400 hours).

Non-Choice Port or Non-Choice Area: Any port that is not classified as a Choice Port, and any area that is not a Choice Area.

Participant: An Active Employee or Pensioner who is eligible for Welfare Plan benefits.

Pay Guarantee Plans (PGP): The ILWU-PMA Pay Guarantee Plan and the lLWU-PMA Walking Bosses/Foremen Pay Guarantee Plan.

Payroll Year: The year that PMA establishes annually for payroll accounting purposes. The Payroll Year may not exactly coincide with the calendar year.

Pensioner: A longshore worker who retires under the ILWU-PMA Pension Plan, the ILWU-PMA Watchmen Pension Plan, a Social Security Retiree, or certain individuals who retire from employment at the ILWU, the Benefit Plans Office, and ILWU locals, as described in the Letter of Understanding between the parties dated August 13, 1997. Welfare Plan eligibility for these groups is described below.

Under the ILWU-PMA Pension Plan: If you are a disability Pensioner, you have Welfare Plan eligibility. Also, if you are a longshore worker who was registered when you retired on a normal pension with a separation date on or after July 1, 1984, you will have Welfare Plan eligibility unless you fall into one of the following groups:

- Pensioners whose separation date was on or after July 1, 1988 and who accrued fewer than 5 years of credited pension service.
- Deferred Pensioners whose separation date was before age 55 or whose normal pension benefit has not commenced.

Under the ILWU-PMA Watchmen Pension Plan: If you are a disability Pensioner, you have Welfare Plan eligibility. Also, if you are a Watchman who was registered when you retired on a normal pension, you have Welfare Plan eligibility, provided that (a) if you are a Pensioner with a separation date on or after July 1, 1990, you have accrued 10 or more years of credited pension service; or (b) if you are a Pensioner with a separation date before July 1, 1990, and you have 13 or more years of service.

Plan Year: The Welfare Plan's fiscal year, which is the 12-month period ending June 30.

Registration: The status established under any of the procedures jointly administered by the Union or its locals and PMA for selecting employees who are deemed to be permanently attached to the industry.

Social Security Retiree: If you (a) are a person who was a registered longshore worker as of the date you commenced receiving benefits under the Federal Insurance Contributions Act, (b) are not certified as eligible to receive and/or are not receiving a pension computed under either the ILWU-PMA Pension Plan or under the ILWU-PMA Watchmen Pension Plan, and (c) are not working under a Collective Bargaining Agreement or other contract or arrangement described in paragraphs 1.10 and 4.4, respectively, of the Fourth Amended ILWU-PMA Welfare Agreement, you have Welfare Plan eligibility.

Notes