Summary Plan Description for the USMX-ILA COVID Pandemic Relief Fund

I. Introduction

This booklet is the Summary Plan Description ("SPD") for the benefits provided by the USMX-ILA COVID Pandemic Relief Fund (the "Fund" or "Plan"), effective February 1, 2020. The Fund is set up as a welfare fund under the Employee Retirement Income Security Act of 1974 and as a supplemental unemployment benefit fund under 26 U.S.C. § 501(c)(17). The complete provisions governing your rights to receive benefits from the Fund are set forth in the Agreement and Declaration of Trust and Plan (the "Trust Agreement").

The purpose of the Plan is to provide for payment of supplemental unemployment benefits to certain employees whose employment is involuntarily terminated due to certain effects of the COVID-19 pandemic. Your employer, as well as each of the employers bound by the 2018-2024 USMX-ILA Master Contract, recognizes that state unemployment benefits, and other federal and state governmental benefits, as well as benefits from local collective bargaining agreements, may be insufficient to assist you while you are unemployed; therefore, the Plan's benefits are provided to supplement these governmental and contractual benefits.

In the event of any omission in this booklet or any conflict between the contents of this booklet and the contents of the Trust Agreement, the terms of the Trust Agreement and the decisions of the Board of Trustees will control.

II. Eligibility for Benefits

The Plan allows you to receive the maximum state unemployment benefits and other federal and state benefits designed to assist workers affected by COVID-19 in coordination with and supplemented by the benefits provided by the Plan. Therefore, eligibility for state unemployment benefits and other governmental benefits will partially determine your eligibility for Plan benefits.

You will be eligible for Plan benefits if you have worked as a longshoreman, checker, clerk, or M&R worker, and you were employed under the 2018-2024 USMX-ILA Master Contract for sixty (60) or more hours from January 1, 2020 until the date of your involuntary loss of work. You will be eligible for Plan benefits for the period of time you are not working because of the COVID-19, pandemic, only if:

- You have tested positive for COVID-19 (must provide evidence of a positive test); OR
- You have been quarantined by your employer or by a doctor because you have had close contact with a person who has tested positive for COVID-19 or who has symptoms of COVID-19 (you should provide evidence of a test when available); OR

- You are caring for a person afflicted with COVID-19 (you must provide evidence of a positive test) who lives in the same residence as you.

You will qualify for Plan benefits only if you have applied for state unemployment benefits. You will be required to provide evidence of your application and the amount of state unemployment benefits you are receiving, if any. If you are denied state unemployment benefits, you must apply for other federal and state governmental benefits and local labor contract benefits, including, for example, state or contractual temporary disability benefits, sick leave or family leave benefits under the federal Families First Coronavirus Response Act, state sick leave benefits, or state paid family leave benefits.

Your Plan benefits will not be subject to taxes under the Federal Insurance Contributions Act (FICA), the Federal Unemployment Tax Act (FUTA), and state unemployment insurance statutes. However, your benefits will be reduced by all other amounts required to be withheld by law, such as, for example, federal and state income taxes.

III. Weekly Benefit Amount

If you are eligible for benefits from the Plan, you will be entitled to a weekly amount of Plan benefits that, when added to your weekly state unemployment benefits, other federal and state governmental benefits, and local contractual benefits, will give you a weekly income equal to two-thirds (2/3) of your 2019 average weekly wage, or $1,550.00, whichever is less.

If you did not earn wages in 2019, then your average weekly wage will be calculated based on the last full year you received wages from industry employers. If you did not work for substantially all of any prior year, your average weekly wage will be based on the wages of employees who did work and who are in a similar situation to you.

If you first started work in the industry in 2020, then your average weekly wage will be calculated based on the wages you received from industry employers in 2020. When applying for benefits under this Plan, you must provide copies of your W-2 for the last full year you received wages from industry employers, or copies of your pay stubs for wages you got from industry employers in 2020.

If you die before receiving or cashing a check for benefits from the Plan, then your benefit will be made to your surviving spouse. If you have no surviving spouse, then the payment will be made to your estate.

IV. No Interest in Plan Assets

You have no right to any Plan benefits until after you are unable to work because of COVID-19 and you become eligible for state unemployment benefits or other governmental and local labor contract benefits and you otherwise satisfy all the requirements set forth in the Plan to receive benefits. Until that time, you shall have no right, title, or interest in benefits under the Plan.

V. No Assignment of Benefit

You do not have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, or commute any benefits due you from this Plan. In addition, except as otherwise provided by law, property held by the Fund is not subject to any legal process, to levy, to execution upon, to attachment, to garnishment, to bankruptcy and insolvency proceedings, or to any action by any creditor for payment of any obligation or debt incurred by you.

VI. Exclusive Benefit

The Trustees shall administer the Plan solely in the interests of the participants for the exclusive purposes of providing benefits and defraying the reasonable expenses of administering the Plan.

VII. Application for Benefits and Appeal Procedure

In order to apply for benefits, you must contact the local Port Association or local employee-benefits funds in the Port where you work to obtain an application. You will be required to complete and submit an application with documentation in support of your application, including:

(i) Evidence of your positive COVID-19 test or for the person you are caring for at home;
(ii) Evidence of the time period when you were quarantined by your employer or doctor;
(iii) Evidence that you applied for state unemployment benefits and proof of the amount of benefits you received;
(iv) Evidence of other governmental and contractual benefits you applied for and received; and
(v) Evidence of your average weekly wage in 2019 (for example, your W-2 tax form).

The Port Association or local employee-benefits fund in the port in which you work will obtain other evidence from your employer relating to your application and then submit your application and all supporting documentation to the Fund, which will review your application. If you are approved for Plan benefits, you will receive those benefits from the Plan or from a designated local joint labor-management trust fund.

If you do not receive benefits which you believe you are entitled to, you must file a written claim for that benefit payment with the Plan no later than three (3) months after the date on which your application for benefits was filed with the local Port Association or local employee-benefits fund. If you do not file a timely claim, you will lose the right to receive the benefits in question.

If your grievance is denied, you will be notified in writing of the denial by certified mail, return receipt requested no later than 60 days after the Plan's receipt of your grievance. That notice will set forth (i) the specific reason(s) for the denial, (ii) the applicable provision(s) of the Trust Agreement and Plan on which the determination is based, (iii) if additional material or information is required to make a determination, a description of the material or information required as well as an explanation as to why such material or information is necessary, (iv) if any internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, the specific internal rule, guideline, protocol, or other similar criterion, and (v) a description of the Plan's appeal procedure and the time limit for bringing an appeal, including a statement of the right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.

If the Plan determines that special circumstances require an extension of time for processing your claim, written notice of extension will be provided to you before the expiration of the initial 60-day period. In no event will the extension period exceed a period of 15 days from the end of the initial period. The extension notice will set forth the circumstances requiring the extension of time and the date by which the Plan expects to render a decision on your claim. If the extension of time is necessary because you failed to submit information necessary to make a determination, the extension notice will specifically describe the required information, you will be afforded 45 days from receipt of the extension notice within which to provide the specified information, and the period of time for making the determination will be tolled from the date on which the extension notice is sent to you until the date on which you respond to the request for additional information.

You will have no more than 60 days from the date on which you receive the denial notification to file an appeal with the Board of Trustees. The appeal must be in writing and set forth the reason(s) for the appeal. It must be mailed to the Board of Trustees by certified mail, return receipt requested, or be delivered personally to the Plan Office. In preparing an appeal, you have the right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. A document, record, or other information is considered relevant to a claim if the document, record, or other information (1) was relied upon in making the benefit determination, (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether the document, record, or other information was relied upon in making the benefit determination, and (3) demonstrates compliance with claims procedures that contain administrative processes and safeguards that are designed to ensure and verify that benefit-claim determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly-situated claimants. You also have the right to submit written comments, documents, records, and other information relating to the claim. The review of your appeal by the Board of Trustees will take into account all comments, documents, records, or other information that you submit relating to the claim, without regard to whether that material was submitted or considered

in the initial determination. The Board of Trustees will not afford deference to the initial determination denying the claim.

If you fail to file an appeal within the 60-day period, you will be deemed to have waived the right to appeal, and the decision denying your claim will be conclusive, final, and binding.

If you file a timely appeal with the Board of Trustees, you will be informed of the determination of the Board of Trustees on the appeal no later than 60 days after that appeal has been received by the Plan. The determination notice will be sent to you by certified mail, return receipt requested. The determination notice will set forth (i) the specific reason(s) for the adverse determination, (ii) the specific provision(s) of the Plan on which the adverse determination is based, (iii) a statement that you may request free of charge reasonable access to and copies of all documents, records, and other information relevant to your claim, (iv) any internal rule, guideline, protocol, or other criterion relied upon in denying your claim, and (v) a statement of your right to bring an action under Section 502(a) of ERISA. The determination of the Board of Trustees on your appeal is conclusive, final, and binding.

If the Board of Trustees determines that special circumstances require an extension of time for processing your appeal, written notice of the extension will be sent to you before the expiration of the initial 60-day period. In no event will the extension exceed a period of 30 days from the end of the initial 60-day period. The extension notice will set forth the special circumstances requiring an extension of time and the date by which the Board of Trustees expects to render its determination on your appeal. If the extension of time is necessary because you have failed to submit information necessary to make a determination, the period of time for making the determination will be tolled from the date on which the extension notification is sent to you until the date on which you respond to the request for additional information.

The 60-day period to render a determination on your appeal may be extended to not more than 90 days if you request a hearing. If you wish, you may appear personally before the Board of Trustees with respect to your appeal with or without an attorney or other duly authorized representative. You will be notified in writing of the date and place of the hearing on your appeal at least seven days before the scheduled date. If you or your duly authorized representative does not appear at the hearing, the Board of Trustees will conduct the hearing as though you or your duly authorized representative were present.

VIII. Factual Findings and Plan Interpretations

With respect to any claim or appeal, the Board of Trustees shall be the sole judges of the standard of proof required in any case and factual findings by the Board of Trustees shall be final and binding. In this regard, each participant making a claim or appeal under this SPD shall furnish to Board of Trustees any information or proof determined by the Trustees or their agent to be reasonably necessary for the administration of the benefit or for the determination of any matter before the Board of Trustees. The Board of Trustees has the sole and exclusive discretion to

construe and interpret this SPD and such constructions and interpretations shall be final and binding.

IX. Amendment and Termination

USMX and the ILA reserve the right to change, alter, or amend the Plan. The Plan will terminate on September 30, 2024.

X. Your ERISA Rights

The following information must be provided to you under ERISA:

A. Plan Sponsor and Plan Administrator

Board of Trustees of the USMX-ILA COVID Pandemic Relief Fund

125 Chubb Avenue, Suite 350NC
Lyndhurst, New Jersey 07071
(732) 404-3100
EIN: 85-0748896

B. Agent for Service of Legal Process

Should it be necessary to serve legal papers on the Plan, the agent for service is the Board of Trustees of the USMX-ILA COVID Pandemic Relief Fund:

125 Chubb Avenue, Suite 350NB
Lyndhurst, New Jersey 07071
(732) 404-3100

Any individual Trustee of the Plan may be served with legal papers on behalf of the Board of Trustees.

C. Source of Contributions

Benefits under the Plan are funded by contributions under the 2018-2024 USMX-ILA Master Contract. Upon written request, a complete list of the participating employers may be obtained from the Plan Administrator.

D. Collective Bargaining Agreement

The Fund and Plan is maintained pursuant to the Master Contract between USMX and the ILA. Upon written request, you may obtain a copy of the collective bargaining agreement from the Plan Administrator. A copy of the collective bargaining agreement may be examined at the Plan Office.

E. Plan Eligibility and Benefits

Refer to the appropriate sections for details of the Plan regarding participation and commencement of benefits.

F. Members of the Board of Trustees

The members of the Board of Trustees of the USMX-ILA COVID Pandemic Relief Fund are as follows:

Union Trustees	Management Trustees
Dennis A. Daggett	F. Paul DeMaria
Michael Vigneron	Anissa Frucci
Alan A. Robb	John J. Nardi

STATEMENT OF PARTICIPANT'S RIGHTS AND PROTECTIONS UNDER ERISA

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

A. **Examine**, without charge, at the Plan Administrator's Office all Plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest Annual Report (Form 5500) filed by the Plan with the Employee Benefits Security Administration of the U.S. Department of Labor;

B. **Obtain**, upon written request to the Plan Administrator (Board of Trustees), copies of documents governing the operation of the Plan, including collective bargaining agreements and copies of the latest Annual Report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for copies; and

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 the Summary Annual Report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee-benefit plan. The people who administer your Plan are called "Fiduciaries." They have a duty to operate the Fund and Plan prudently and in your interest as well as the interests of the other Plan Participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a lawsuit in a state or federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic-relations order you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration ("EBSA") of the U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. The telephone number is 866-444-3272.