



**MILA
NATIONAL
HEALTH
PLAN**

**RETIREE-ONLY
MEDICARE PART B PREMIUM
PAYMENT REIMBURSEMENT PLAN**

March 23, 2026

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**MILA NATIONAL HEALTH PLAN
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MEDICARE PART B PREMIUM
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PREAMBLE & INTRODUCTION

THIS INSTRUMENT, made and published by the Management-International Longshoremen’s Association Managed Health Care Trust Fund (hereinafter called “MILA”), pursuant to a collectively bargained agreement between the International Longshoremen’s Association (ILA) and the United States Maritime Alliance, Ltd. (USMX) (collectively, the “Plan Sponsors”) to resolve in full and in perpetuity any and all disputes and disagreements relating to the Initial Pensioner issue, describes the MILA National Health Plan Retiree-Only Medicare Part B Premium Payment Reimbursement Plan, a plan which provides to certain eligible retirees, and certain of their eligible spouses, as defined herein, reimbursement for the payment of Medicare Part B premiums for a period of up to 24 months from the date of the relevant eligible retiree’s retirement.

Effective Date. The Plan became effective for eligible retirees with retirement dates on or after October 1, 2023.

ARTICLE 1

DEFINITIONS

Section 1.01. Definitions of the MILA National Health Plan Govern. For any term not expressly defined in this Article 1, the terms used within the Plan shall have their ordinary and customary meaning, unless such term has instead been expressly defined in the MILA National Health Plan, in which case the definition of the term as defined therein shall govern.

Section 1.02. Eligible Retiree and Eligible Retiree Spouse. An Eligible Retiree or an Eligible Retiree Spouse is an individual who is entitled to benefits under the Plan in accordance with Article 2 herein.

Section 1.03. In the Industry. For purposes of this Plan, the term “in the industry” shall mean that the Eligible Retiree, while actively employed, performed work under the Master Contract or one of its predecessor agreements.

Section 1.04. Medicare Part B Premium. References herein to the Medicare Part B Premium refer to the monthly premium payments that an Eligible Retiree or Eligible Retiree Spouse must pay to obtain Medicare Part B coverage.

Section 1.05. Medicare Income-Related Monthly Adjustment Amount (IRMAA). The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an additional amount that an individual must pay over the standard monthly Medicare Part B Premium due to higher annual earnings. The Social Security Administration (SSA) determines whether an individual is subject to IRMAA in any given year based upon the Adjusted Gross Income (AGI) listed on the individual’s tax returns for the two preceding years.

Section 1.06. Trustees. The term “Trustees” shall mean the Plan’s Board of Trustees, which shall be the same as the Board of Trustees for the MILA National Health Plan.

ARTICLE 2

ELIGIBILITY

Section 2.01. Eligible Retiree and Eligible Retiree Spouse. An Eligible Retiree is an Eligible Employee who (1) qualifies for MILA Pensioner benefits under Section 2.03 of the MILA National Health Plan, (2) retires from employment in the industry with at least 25 years of service, (3) pays at least one monthly Medicare Part B Premium payment, based upon the Eligible Retiree’s having attained age 65, in accordance with Articles 2 and 3 of this Plan within the 24-month period commencing on the date of the Eligible Employee’s retirement, and (4) has not had his/her benefits under the MILA National Health Plan suspended due to the application of its provisions concerning subrogation, reimbursement, or overpayment. An Eligible Retiree Spouse is the Spouse of an Eligible Employee under Section 1.11.05 of the MILA National Health Plan on the date of the

Eligible Employee's retirement where the Eligible Employee is eligible for benefits under Section 2.03 of the MILA National Health Plan based upon the Eligible Employee's having earned at least 25 years of service who (1) has not been terminated in accordance with Section 2.06 of the MILA National Health Plan, (2) pays at least one monthly Medicare Part B Premium payment, based upon the Eligible Retiree Spouse's having attained age 65, in accordance with Articles 2 and 3 of the Plan within the twenty-four month period commencing on the date of the Eligible Employee's retirement, and (3) has not had his/her benefits under the MILA National Health Plan suspended due to the application of its provisions concerning subrogation, reimbursement, or overpayment.

Section 2.02. Duration of Benefits. An Eligible Retiree shall be eligible for benefits from the Plan for those months during the 24-month period commencing on the Eligible Retiree's date of retirement for which the Eligible Retiree has made Medicare Part B Premium payments in accordance with Articles 2 and 3 of the Plan. An Eligible Retiree Spouse shall likewise be eligible for benefits from the Plan for those months during the 24-month period commencing on the Eligible Retiree's date of retirement for which the Eligible Retiree Spouse has made Medicare Part B Premium payments in accordance with Articles 2 and 3 of the Plan.

Section 2.03. Eligible Retirees who Return to Active Service. The eligibility of an Eligible Retiree who returns to active service, *see* Section 2.01.10 of the MILA National Health Plan shall cease permanently upon the Eligible Retiree's return to active service. The eligibility of an Eligible Retiree will cease permanently in the event an Eligible Retiree returns to active service. Neither the Eligible Retiree nor the Eligible Retiree Spouse will be eligible for benefits from the Plan should the Eligible Retiree retire a second or more times from active service.

Section 2.04. Date Benefits Become Payable under this Plan. The benefits provided by the Plan commence with respect to Eligible Retirees who retire on or after October 1, 2023.

Section 2.05. Required Documents for Payment of Benefits. To be eligible for benefits from the Plan, the Eligible Retiree and the Eligible Retiree Spouse, if applicable, must submit to the Plan Office proof of the Eligible Retiree's retirement; proof of enrollment of the Eligible Retiree and the Eligible Retiree Spouse, if applicable, in Medicare Parts A and B; and proof of the payment of a Medicare Part B Premiums by the Eligible Retiree and Eligible Retiree Spouse before the Plan will issue any reimbursement(s). Proof of payment of Medicare Part B Premiums shall be established through the submission of a copy of Form SSA-1099. To the extent that Medicare Part B Premiums were not paid through deductions from Social Security payments, and thus were not reportable on Form SSA-1099, proof of the payment of Medicare Part B Premiums shall be established through the submission of written proof satisfactory to the Plan Administrator, such as a payment history statement generated by Medicare's website at <https://www.medicare.gov/my/premiums/history> or a letter from the Social Security Administration setting forth the amounts of the required Medicare Part B Premium payments.

ARTICLE 3

REIMBURSEMENT OF MEDICARE PART B PREMIUM PAYMENTS

Section 3.01. Reimbursement of Medicare Part B Premium Payments. The Plan shall reimburse monthly Medicare Part B Premium payments made by an Eligible Retiree and Eligible Retiree Spouse, if applicable, in the full amount paid by the Eligible Retiree and Eligible Retiree Spouse, if applicable, including any applicable addition to the standard Medicare Part B Premium payable to account for an IRMAA adjustment, but not including any other portion of the Medicare Part B Premium attributable to any late entrant penalty, premium surcharge, or any other such fees, penalties, or surcharges, in accordance with Article 2 of the Plan.

Section 3.02. Payment of Reimbursements. Form SSA-1099 is issued each year in or about January. The Plan will reimburse Medicare Part B Premium payments made by Eligible Retirees and Eligible Retiree Spouses in a reasonably practicable time following the Plan's receipt of proof of eligibility for MILA pensioner benefits, enrollment in Medicare Part B, and payment in accordance with Section 2.05 of the Plan, as well as the Plan's receipt of a Claim in accordance with Article 5 of the Plan.

ARTICLE 4

GENERAL PROVISIONS

Section 4.01. Non-Assignment of Benefits. Except as expressly provided herein, there shall be no right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute or anticipate any benefit payment hereunder, and any such payment shall not be subject to any legal proceeding for levy, execution, attachment, or garnishment.

Section 4.02. Recovery of Overpayments. In the event of any overpayments made by the Plan, the Trustees shall have the right, exercisable alone and at their sole discretion, to recover such overpayments to the extent of such overpayment from among one or more of the following as the Trustees shall determine: any persons to, or for, or with respect to whom, or on behalf of whom, the Plan payments were made.

If a benefit payment exceeds the benefit amount that an Eligible Retiree or Eligible Retiree Spouse, if applicable, was entitled to receive, the Plan has the right to (1) require the return of the overpayment and (2) reduce by the amount of the overpayment any future benefit payment made to or on behalf of the Eligible Retiree or Eligible Retiree Spouse, if applicable, regardless of who received the overpayment. This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Failure to reimburse the Plan for such overpayment within four weeks from the date of the demand by the Plan for repayment of the overpayment may in the Trustees' discretion disqualify the Eligible Retiree and Eligible Retiree Spouse, if applicable, from receiving any future benefits under the Plan, and may result in the pursuit of legal action. The Trustees may also in their discretion suspend the benefits of the Eligible Retiree and Eligible Retiree Spouse until repayment of the overpayment has been made in full.

Section 4.03. Rescission. Coverage may be terminated retroactively (rescinded) in cases of fraud or intentional misrepresentation (the Eligible Retiree and Eligible Retiree Spouse, if applicable, will be provided with 30 days' advanced notice).

Section 4.04. Amendments. The Plan's Trustees shall have the right, in its discretion, to alter or terminate the amount or conditions hereof with regard to any benefit, and otherwise to amend any other provisions of this plan document. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

- Amendments to the Plan may be made in writing by agreement of the Plan Sponsors or the Board of Trustees and become effective on the written approval of the Plan Sponsors or the Board of Trustees or on such other date as may be specified in the document amending the Plan.
- The Plan or any coverage under it may be terminated and new coverages may be added by the Plan Sponsors or the Board of Trustees.

Section 4.05. Allocation and Disposition of Assets Upon Termination. In order for the Plan to carry out its obligation to provide the maximum possible benefits to all Eligible Retirees and Eligible Retiree Spouses, if applicable, within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by the Plan.

- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of the Plan.

In addition, the Plan may be terminated by an agreement of the Plan Sponsors or the Trustees, provided that written notice of such termination is provided to each Eligible Retiree and Eligible Retiree Spouse, if applicable, and that the termination is not effective until 60 days after the mailing of such notice.

In the event the Plan terminates, the Board of Trustees, by unanimous agreement and in its full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and trust have been paid, provided that any such distribution will be made only for the benefit of former participants of the MILA National Health Plan and former Eligible Retirees and former Eligible Retiree Spouses and for the purposes set forth in the Plan.

Upon termination of the Plan, the Board of Trustees, which is the Plan Administrator (with full power), will continue in such capacity for the purpose of dissolution of the Plan.

Section 4.06. Requirement to Cooperate with the Plan. An Eligible Retiree and Eligible Retiree Spouse must cooperate with the Plan, provide all information requested by the Plan, and must take any further actions the Plan may reasonably require. Any Eligible Retiree or Eligible Retiree Spouse who fails to respond to any request for information sent to the Eligible Retiree or Eligible Retiree Spouse by the Plan or any entity acting on behalf of the Plan will have their benefits suspended on whatever terms and conditions the Trustees deem appropriate.

Section 4.07. Plan Administrator. The Board of Trustees shall serve as the Plan Administrator, any provision within this Plan Document to the contrary notwithstanding.

Section 4.08. Interpretation. The Board of Trustees shall have the right, in its discretion, to interpret and construe the terms and provisions of this Plan Document and any such interpretation or construction shall be final and binding upon all persons concerned.

Section 4.09. Notice of Denial. The Plan's procedures for the submission and processing of Claims, and the appeals of decisions regarding Claims are set forth in Article 5 of the Plan.

Section 4.10. Titles Not Binding. The titles set forth in this Plan are included for purposes of identifying the sections. Nothing in the titles shall be used to interpret the section.

Section 4.11. Use and Disclosure of Protected Health Information (PHI). The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA,) and as set forth within Section 10.12 of the MILA National Health Plan, which terms are incorporated as if stated fully herein.

ARTICLE 5

CLAIMS AND APPEALS PROCEDURES

Section 5.01. Definitions. For purposes of dealing with claims under this Article words or phrases shall have the following meanings:

Section 5.01.01. Claim. A "Claim" is a written or electronic request for a Plan benefit.

Section 5.01.02. Claimant. A "Claimant" is an Eligible Retiree or an Eligible Retiree Spouse, or an authorized representative of an Eligible Retiree or an Eligible Retiree Spouse, who submits a Claim.

Section 5.01.03. Receipt of Claim. A Claim is considered received by the Plan when the request contains enough information to determine the eligibility of the person seeking a benefit and enough information to permit the Plan to make payment to the appropriate party. An oral request for a Plan benefit will not be accepted as a Claim.

Section 5.01.04. Authorized Representative. An “Authorized Representative” is a person or organization who demonstrates the authority to act on behalf of an Eligible Retiree or an Eligible Retiree Spouse with respect to a Claim or the appeal of an Adverse Benefit Determination regarding a Claim.

Section 5.01.05. Adverse Benefit Determination. An “Adverse Benefit Determination” is any denial, reduction, termination of, or failure to make payment of a benefit in whole or in part. A situation where an initial determination of a benefit is re-evaluated and the new decision is a reduction or elimination of a benefit will also be considered an Adverse Benefit Determination.

Section 5.02. Claims. An Eligible Retiree or an Eligible Retiree Spouse, or the Authorized Representative of an Eligible Retiree or an Eligible Retiree Spouse, may submit a claim to the Plan during regular business hours. Claims for Medicare Part B Premium payments made on or after January 1, 2026, must be submitted to the Plan no later than August 1 of the Calendar Year immediately following the Calendar Year in which the Medicare Part B Premium payments were made by the Eligible Retiree or Eligible Retiree’s Spouse, as applicable. Claims for Medicare Part B Premium payments made by an Eligible Retiree or Eligible Retiree’s Spouse, as applicable, between October 1, 2023, and December 31, 2025, must be submitted to the Plan no later than September 30, 2026. A failure to submit a timely claim will result in the denial of that claim. Within 30 calendar days after receipt of a Claim the Plan will notify the Claimant of its decision on the Claim. If the Claimant failed to provide information necessary to process the Claim, the Plan will notify the Claimant that additional, specified information

is needed and that the 30-calendar-day deadline for processing the Claim is being extended another 15 calendar days, or until the Claimant submits the required information. The Claimant will have 60 days to provide the needed information. The Plan will issue a decision on the Claim within 30 days of receipt of the information or, if information is not provided by the Claimant on a timely basis, at the end of the 60-day deadline. If the required information is not received by the end of the 60-day deadline, the Claim will be denied.

Section 5.03. Extension of Deadlines. If the Plan determines that it is necessary to extend the 30-day deadline for a Claim due to matters beyond the control of the Plan, then the original deadlines for issuance of a decision on the Claim will be extended 15 calendar days. The Plan will notify the Claimant of this extension.

Section 5.04. Failure to Follow Claims Procedures. A Claimant who fails to follow the Plan's procedures for filing any Claim will be notified by of the steps which should be taken to validate the Claim.

Section 5.05. Notice of Claims Decisions. For each Claim submitted, the Plan shall issue a written notice describing the Plan's decision concerning the Claim. If the decision includes an Adverse Benefit Determination, then the notice will include:

- a. The specific reason or reasons for the Adverse Benefit Determination;
- b. Reference to the specific provisions on which the Adverse Benefit Determination is based;
- c. When appropriate, a description of any additional information or material necessary for the proper processing of the Claim, and the reason it is needed;
- d. A copy of the Plan's appeal procedures, including the deadline for appealing the Claim, and a statement about the Claimant's right to bring suit; and

- e. When appropriate, a copy of any internal rule, guideline, protocol, or criterion that was relied upon in making the determination. In the alternative, the notice may indicate that such guidelines are available at no cost at the Claimant's request.

Section 5.06. Appeal Rights for Adverse Benefit Determinations. An Eligible Retiree or an Eligible Retiree Spouse, or the Authorized Representative of an Eligible Retiree or an Eligible Retire Spouse, shall have the right to an appeal after receiving an Adverse Benefit Determination. An appeal must be made within 180 days after the Claimant receives notification of the benefit determination and must be in writing. The appeal may include comments, documents and other information that the Claimant believes is relevant, regardless of whether such information was submitted or considered in the initial benefit determination. A Claimant making an appeal may request, without charge, access to and copies of all documents, records or other information in the possession of the Plan, which is relevant to the Claim.

Section 5.07. Appeal of Claims. The Plan will issue a decision on the appeal of a Claim within 60 days of receipt of the appeal.

Section 5.08. Action by Trustees. The Plan's Board of Trustees, or a committee thereof, shall make decisions on all Claims and appeals of determinations on Claims. The Board of Trustees shall have sole and absolute discretionary authority (a) to determine eligibility for benefits, (b) to interpret and construe the terms and provisions of the Trust and Plan, and (c) to make factual findings in connection with applications for benefits and to make other determinations involving application of the provisions of the Plan. All decisions of the Board of Trustees shall be conclusive, final, and binding.

Section 5.09. Legal Actions. No legal action against the Plan may be brought in any jurisdiction to obtain Plan Benefits unless a Claimant has followed the appeals procedures contained in this Article 5 and then not until after a decision has been

communicated to the Claimant within the time periods set forth herein. No legal action may be started against the Plan in any jurisdiction more than 2 years after a Claim was required to be filed with the Plan Administrator, but not including any period between the time an appeal was submitted and the time a decision on that appeal was made.