MILA MANAGED HEALTH CARE TRUST FUND

December 17, 2018

TO: All Eligible Participants

FROM: La Verne Thompson, Executive Director

Season's greetings for a safe and healthy holiday season to you and your family from the MILA Co-Chairmen, Benny Holland, Jr. and David F. Adam, as well as all of the MILA Trustees, and the MILA staff.

In our efforts to provide you with important information concerning the operation of the MILA National Health Plan, we are enclosing:

- The MILA National Health Plan Summary Annual Report, which summarizes MILA's 2017 annual financial filing with the government
- The Summary of Material Modifications for 2018, which outlines the significant changes/clarifications in the Plan's benefits adopted during 2018, including the following:
  - Grandfathered Health Plan Notice.
  - Important Reminders and Notices including:
    - Special Enrollment
    - Rescission of Coverage
    - COBRA Continuation of Coverage
    - Women's Health and Cancer Rights Act of 1998 (WHCRA)
    - Newborn's and Mothers' Health Protection Act Annual Notice Reminder
    - Additional Information and Updates to the Summary Plan Description
    - **Mandatory Notification of Divorce – Your MILA Coverage can be Suspended**
- Information for Medicare Eligible MILA Retirees
- **Important Warning: For Actives/Retirees who are Eligible for Medicare**
- Information on MILA/Cigna Programs and Cigna Policy Updates
- Information on MILA/CVS Caremark upcoming programs (Minute Clinic & Vaccination)
- Notice of Non-Discrimination
- MILA Privacy Notice

If you have any questions about any of these documents, please contact the MILA office.

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MILA National Health Plan
Summary Annual Report

This is a summary of the annual report of the MILA National Choice Plan (Employer Identification Number 13-3968546), a collectively bargained multi-employer health and welfare plan, for the twelve months ending December 31, 2017. The annual report has been filed with the Department of Labor as required under the Employee Retirement Income Security Act of 1974 (ERISA).

All benefits payable under this plan are being provided on an uninsured basis. The Management-ILA Managed Health Care Trust Fund has committed itself to pay all claims incurred under the terms of the plan.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $862,729,131 as of December 31, 2017, compared to $797,824,096 as of January 1, 2017. During the plan year the plan experienced an increase in its net assets of $64,905,035. This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $675,629,513, including employer and other contributions of $533,112,683, gains on the sale of assets of $1,025,430, unrealized gains from investments of $71,380,425, and interest and dividend income of $10,811,574. Plan expenses were $610,724,478. These expenses included $6,871,953 in administrative expenses, and $603,852,525 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. An accountant's report plan financial information and information on payments to service providers, assets held for investment, and transactions in excess of 5% of plan assets are included in that report. To obtain a copy of the full annual report, or any part thereof, write Ms. Laverne Thompson, Executive Director, Management-ILA Managed Health Care Trust Fund (MILA-MHCTF), 111 Broadway-5th Floor, New York, NY 10006, or call the MILA office at (212) 766-5700. The charge to cover copying costs for the full annual report is $10.00, or $0.25 per page for any part thereof.

You also have the right to receive from the Executive Director, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the Executive Director, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge. You also have the right to examine the annual report at the main office of the plan at 111 Broadway – 5th Floor, New York, NY 10006, and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to Public Disclosure Room, N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Summary of Material Modifications and Notices and Reminders
MILA Managed Health Care Trust Fund National Health Plan

The current Summary Plan Description (SPD) for the MILA National Health Plan was effective as of May 1, 2015. The Board of Trustees amends the Plan from time to time and informs you of changes. The information in this document summarizes any changes made to the SPD during 2018. In addition, it provides some important Notices and Reminders as well as clarifications that pertain to the SPD and the administration of the Plan. Please keep this letter with your SPD and other plan documents for future reference. If you have any questions, please contact the MILA Plan Office.

AFFORDABLE CARE ACT (ACA) - IMPORTANT INFORMATION

Notice of Grandfathered Plan

The MILA Trustees believe the Premier Plan, the Basic Plan, and the Core Plan are "grandfathered health plans" 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 the provision of preventive health services without any cost-sharing. 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.

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 MILA Executive Director at 212-766-5700. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or access information online at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The MILA Medicare Wrap-Around Plan is considered a “retiree-only” plan and is not subject to the requirements of the ACA that define grandfathered plans. Rather, it is exempt from the provisions of the Affordable Care Act because it covers only retired persons and their dependents, and its benefits are provided to supplement those available from Medicare Parts A & B. In addition, it provides prescription drug benefits that qualify as “creditable coverage” under the regulations governing the requirement to enroll in Medicare Part D. This means that MILA coverage is equal to or better than the coverage provided in Medicare Part D, and persons covered in the MILA Medicare Wrap-Around Plan are not required to enroll in a Part D Plan.

IMPORTANT NOTICE AND REMINDERS

URGENT CARE vs. EMERGENCY ROOM (ER) CARE

Next time you need medical attention, consider your options!

Illnesses and injuries come along when you least expect them. When it is time to make a decision fast, it is good to know your options.

When you have a non-emergency situation, consider using the nearest Urgent Care Center before you go to the ER. Urgent Care Centers offer state-of-the-art facilities, shorter wait times and quality medical care.

Are you "sick" of waiting in the ER? Getting the right care quickly is important.

When should you go to the Emergency Room? When medical attention is needed for life-threatening conditions such as:

- chest pain or pressure
- uncontrolled bleeding
- sudden or severe pain
- coughing or vomiting blood
- difficulty breathing or shortness of breath
- sudden dizziness, weakness, or changes in vision
- severe or persistent vomiting or diarrhea
- changes in mental status, such as confusion

When should you go to the Urgent Care Center? Urgent Care Centers provide prompt treatment for non-life threatening conditions and help you avoid the long waiting times one often encounters when seeking treatment for non-life threatening conditions in the ER.

When medical attention is needed, and you are unable to see your doctor, you can visit your local Urgent Care Center for non-life-threatening conditions such as:

- Colds, flu, fevers
- earaches and sore throats
- sprains and strains
- minor burns
- small cuts
- rashes
- nausea
- migraines
- conjunctivitis (pink eye)
- bladder/urinary symptoms

For information on the Urgent Care Centers near you, you can check the online Provider Director on myCigna.com or Cigna.com, or by calling a customer service representative at the number listed on the back or your MILA/Cigna I.D. card.

NOTE: We want to encourage you to make the best decisions when it comes to your health care, whether that is saving you time or money. In no way do we wish to discourage you from visiting the ER if the need arises.

REMINDERS:

HEARING AIDS: IN-NETWORK ONLY

This benefit is provided through Cigna's relationship with AMPLIFON. This benefit will be $1,500 per ear and is limited to once every 36 months (once every three years). The total benefit is $3,000 every three years.

INFERTILITY BENEFITS: IN-NETWORK ONLY

The coverage for infertility treatments is provided through Cigna Healthcare to actives, retirees, and spouses only - from 21 to 44 years of age. There is a lifetime cap of $40,000:

- $30,000 of the maximum will apply to covered medical services (*The medical maximum will apply to all covered drugs administered in a medical setting)* and
- $10,000 of the maximum will apply to covered drugs through CVS Caremark.

MALE SEXUAL DYSFUNCTION TREATMENT: IN-NETWORK ONLY

The coverage for male sexual dysfunction treatment is provided through Cigna Healthcare to actives, retirees, and spouses only. **There is a lifetime cap of $20,000.** This benefit will be based upon Medical Necessity.

For retirees covered in the MILA Medicare wraparound plan, Medicare will perform the medical necessity review. MILA/Cigna pays secondary to Medicare. **The combined Medicare and MILA benefit cannot exceed $20,000.** Medicare will be your provider for this benefit.

For members covered in the Premier, Basic, and Core plans – co-pays and deductibles will apply.

This coverage includes the:

- Vacuum Constriction Devices- these are covered the same way External Prosthetic Devices and Durable Medical Equipment ae covered. Coverage depends on what the device is.
- Penile Prosthesis – this is a surgical implant.

VACCINES FOR $0.00 COPAY!

The MILA Plan offers a Nationwide Vaccine Network through our PBM. Members age 18 and older can access seasonal flu shots and other non-seasonal vaccinations through any **CVS Pharmacy** locations, as well as most other pharmacies, and have it covered with no out-of-pocket expense.

Just show your **CVS Caremark Rx ID card** to the pharmacist and be prepared to present one form of I.D. (such as a driver's license.)

VACCINATIONS AND INJECTIONS

- Flu (seasonal)
- Hepatitis A (child and adult)
- Hepatitis B (child and adult)
- IPV (polio)
- Meningitis
- MMR (measles, mumps, rubella)
- PPSV (pneumonia)
- Tdap (tetanus, diphtheria, pertussis)
- TD (tetanus, diphtheria)
- Birth control injections (subcategory: contraception)

WELLNESS

- **Screenings:** Basic and comprehensive health screenings, cholesterol and diabetes (glucose)
- Start to Stop® Smoking cessation program
- Weight loss program
- Diabetes
- High blood pressure
- High cholesterol

MINUTE CLINIC - $0 copay!

Select health care services are available to **MILA** members at **CVS Pharmacy Minute Clinic** at no charge**. Minute Clinic** is the walk-in health care center available to all eligible MILA members.

- Open seven days a week, including evenings and weekends
- No appointment necessary
- Check your local **Minute Clinic** for hours of operation and all services offered at **www.cvs.com/minuteclinic** or simply call 1-866-389-2727.
- Check for approximate wait times
- Save time and check-in online – submit your name to hold your place in line

MILA members may utilize Minute Clinics for a variety of services including, but not limited to:

MINOR INJURY / ILLNESS

Minor Illness

- Allergy symptoms
- Bronchitis and coughs
- Earaches and ear infections
- Flu-like symptoms
- Mononucleosis
- Pink eye and styes
- Sinus infections and congestion
- Sore and strep throat
- Upper respiratory infections
- Urinary tract and bladder infections

Minor Injury

- Bug bites and stings
- Minor burns
- Minor cuts, blisters and wounds
- Splinter removal
- Sprains and strains (ankle and knee only)
- Suture & staple removal
- Tick bites

Miscellaneous

- Epi-Pen® refill
- Ear wax removal
- Motion sickness prevention
- One-time medication renewal
- Pregnancy evaluation
- Vitamin B12 injections
- A1c check

Skin condition

- Acne
- Athlete's foot
- Chicken pox
- Cold, canker and mouth sores
- Eczema
- Impetigo
- Lice
- Poison ivy and poison oak
- Ringworm
- Scabies
- Shingles
- Styes
- Sunburn (minor)
- Swimmer's itch
- Wart evaluation

Just show your **CVS Caremark Rx ID card** to the pharmacist and be prepared to present your one form of I.D. (such as a driver's license).

NEW BENEFITS FOR CALENDAR 2019

Vision Benefits administered through EyeMed:

The following changes will be effective January 1, 2019

- The frame allowance will increase from $100 to $130, once every 24-months.
- With a special offer from **Sears® Optical and Target Optical** only, you're free to choose any frame in these two stores at no additional cost to you. For example, if you purchase a pair of brand name frames at Sears or Target that retails for $200, your out-of-pocket cost is still $0. As a reminder, lenses are covered based on the benefits outlined in your MILA Summary Plan Description (SPD) and may include an additional copay. Please visit the EyeMed.com provider locator, or call Member Services on your EyeMed I.D. card, for more information

Dental Benefits administered through Aetna:

The following changes will be effective January 1, 2019:

- The missing tooth exclusion will no longer apply.
- The Plan will cover orthodontia for adults, when medically necessary. The coverage will be subject to a $1,500 per person per **lifetime maximum**. Benefits payable out of network will be paid based on a charge which would have been eligible if it had been rendered by a Network dentist operating in the Network. Any additional charge presented by that out-of-network dentist will be the member's responsibility.
- The Plan will cover dental implants (when medically necessary) subject to a $5,000 per person per calendar year maximum. This is a separate calendar year maximum.

CVS/CAREMARK ALSO OFFERS TO ALL OUR ELIGIBLE MEMBERS

Blood Glucose Meter- LIVONGO

There's an easier way to help manage diabetes.

If you have been diagnosed with diabetes, you qualify for our new connected Livongo blood-glucose meter. It is available to you as part of a new diabetes program through your CVS Caremark/MILA National Health Plan.

This program includes these services at no cost to you:

- A smart touchscreen blood-glucose meter
- Unlimited test strips
- One-on-one coaching
- Personalized tips

To get started you must register at start.livongo.com or call 1-800-945-4355 – provide code: MILA

Drug Formulary

The MILA drug plan has a list of prescription drugs (called a formulary) that MILA covers. The MILA plans cover both generic and brand-name prescription drugs. The formulary must include a range of drugs in the most commonly prescribed categories and classes. This makes sure that people with different medical conditions get the prescription drugs they need.

The formulary may not include your specific drug. However, in most cases, a similar drug should be available. If you or your prescriber *(your doctor or other health care provider who is legally allowed to write prescriptions)* believes none of the drugs on the MILA formulary will work for your condition, your doctor must provide MILA a detailed letter that explains the medical reasons that a similar drug covered by the MILA plan will not work for you. MILA will send this letter to CVS/Caremark for its review. After CVS/Caremark completes its review, a determination will be made as to whether MILA will cover your drug based on your doctor's letter.

If a drug is removed from the MILA drug formulary, in most cases, you will be notified in advance. You may have to change to another drug (that is similar to the one you are taking) on the MILA formulary or pay more to keep taking the drug that you have been taking.

Note: MILA is not required to tell you in advance when it removes a drug from its formulary if the Food and Drug Administration (FDA) takes the drug off the market for safety reasons, but CVS/Caremark will let you know afterward. Generally, using drugs on your plan's formulary will save you money. Using generics instead of brand-name drugs can also save you money.

DIGITAL BREAST TOMOSYNTHESIS (DBT)

Digital Breast Tomosynthesis (DBT), also called 3D mammography, is covered as a preventive benefit under most MILA/Cigna plans.

- **How does DBT differ from 2D digital mammography?**

  Mammography is a test, usually done every year or two, that uses a low-dose X-ray to screen for breast cancer and other breast diseases and to diagnose breast conditions when a screening test shows a problem. A standard mammogram takes digital images of the breast from two angles (also known as 2D digital mammography).

  DBT is different from standard 2D mammography because instead of taking images from two angles, it takes many images in an arc around the breast and creates a 3D image.

- **Are DBT screening tests a covered service?**

  Yes. Based on recent guidance from the National Comprehensive Cancer Network, a not-for-profit alliance of leading cancer centers that set standards for high-quality cancer care, MILA/Cigna has changed its screening mammography coverage policy to cover DBT.

- **Questions or concerns?**

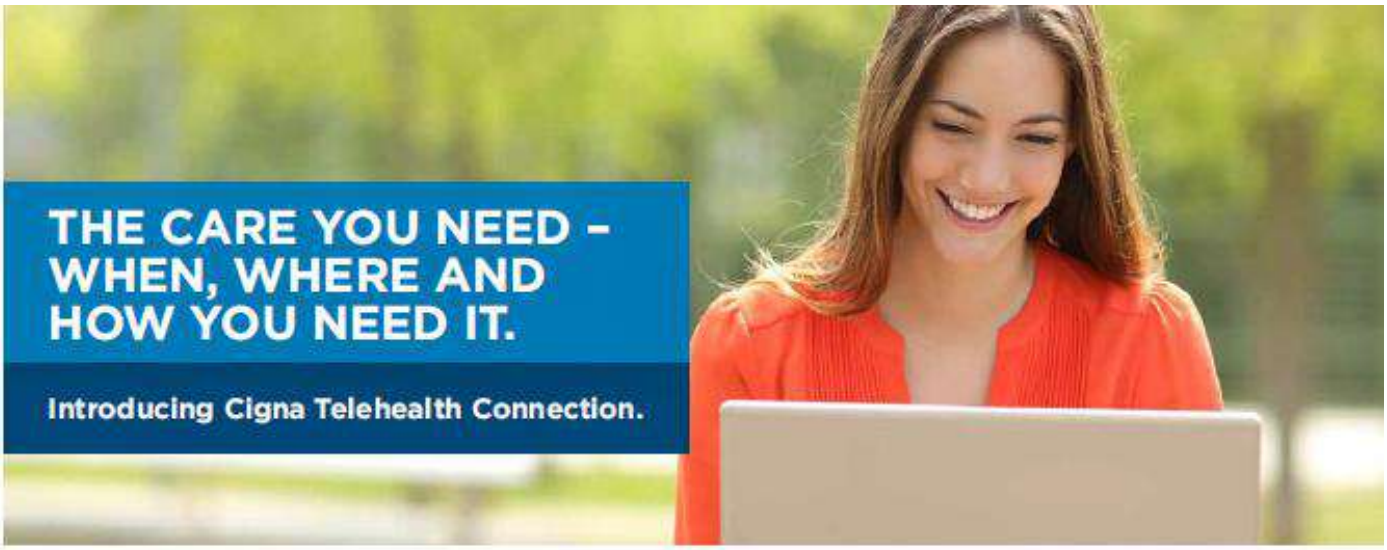
  We're happy to help! Please call us at the number on the back of your Cigna ID card. Our Customer Service Advocates are available 24/7.

TELEHEALTH MEDICINE

Telehealth Medicine services are covered under MILA/Cigna: MILA's Primary Care Physician (PCP) copay will apply to these Telehealth visits. We are providing our members with convenient access to an efficient and cost-effective alternative to in-person care for minor, non-emergency health care issues-when, where and how it works best for them. MILA participants can see a board-certified doctor with private, online, and live appointments via a secure video or phone conversation.

Participants are able to choose from two Telehealth vendors, American Well and MDLIVE. Our members can decide how they want to connect, and the time and day that works best for them. Medical Telehealth services will be available 24/7/365. A Telehealth service provides a more immediate and low-cost alternative to traditional 'in person' care such as ERs, Urgent Care, or Convenience Care Clinics and has the same or lower cost than PCP visits.

Telehealth doctors can treat many common health issues including cold and flu, joint aches and pains, fever, bronchitis, and more. Customers with children can also turn to Telehealth services for non-emergency pediatric care. (See pages 10-11 of this SMM for more information or call the number on the back of your Cigna I.D. card).



Choice is good. More choice is even better.

Now Cigna provides access to **two** telehealth services as part of your medical plan – **AmWell** and **MDLIVE**.

Cigna Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. Now you can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office. When, where and how it works best for you!

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

Choose who: AmWell or MDLIVE doctors.

Say it's the middle of the night and your child is sick. Or you're at work and not feeling well. If you pre-register on both AmWell and MDLIVE, you can speak with a doctor for help with:

- sore throat
- fever
- rash
- headache
- cold and flu
- acne
- stomachache
- allergies
- UTIs and more

The cost savings are clear.

Televisits with AmWell and MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. And the cost of a phone or online visit is the same or less than with your primary care provider. Remember, your telehealth services are only available for minor, non-life threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

AmWell and MDLIVE are only available for medical visits. For covered services related to mental health and substance abuse, you have access to the **Cigna Behavioral Health** network of providers.

- Go to **Cignabehavioral.com** to search for a video telehealth specialist
- Call to make an appointment with your selected provider

Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.

Together, all the way.®

Cigna.

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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Choose with confidence.

AmWell and MDLIVE are both quality national telehealth providers, so you can choose your care confidently. When you can't get to your doctor, Cigna Telehealth Connection is here for you.

Register for one or both today so you'll be ready to use a telehealth service when and where you need it.

AmWellforCigna.com*
855-667-9722

MDLIVEforCigna.com*
888-726-3171

Signing up is easy!

Set up and create an account with one or both AmWell and MDLIVE

Complete a medical history using their "virtual clipboard"

Download vendor apps to your smartphone/mobile device**

Cigna.

*Availability may vary by location and plan type and is subject to change. See vendor sites for details.

**The downloading and use of any mobile app is subject to the terms and conditions of the mobile app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

AmWell and MDLIVE are independent companies/entities and are not affiliated with Cigna. The services, websites and mobile apps are provided exclusively by AmWell and MDLIVE and not by Cigna. Providers are solely responsible for any treatment provided. Not all providers have video chat capabilities. Video chat is not available in all areas. AmWell/MDLIVE services are separate from your health plan's provider network. Telehealth services may not be available to all plan types. A Primary Care Provider referral is not required for AmWell/MDLIVE services.

In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

The Member Assistance Program (MAP) for members and their dependents is provided through Cigna Health Care. It is entirely voluntary and confidential, and offers the following benefits:

PROFESSIONAL COUNSELING FROM LICENSED BEHAVIORAL HEALTH PROVIDERS:

- Up to three, free, face-to-face behavioral health visits with a member of CIGNA Behavioral Health's network of providers
- Household Member Benefit (Anyone living with the member is eligible for MAP)
- Clinical Assistance
- Crisis Intervention
- 24-hour, live telephonic access 365 days per year
- 24-hour crisis intervention support with licensed behavioral health clinicians
- 24-hour telephonic counseling with CIGNA's Masters'- and PhD-level licensed behavioral health clinicians

RESOURCES TO SUPPORT YOUR NEEDS THAT ARE NOT MEDICALLY RELATED SUCH AS:

- **Legal Assistance**: Free 30-minute telephonic or face-to-face consultation with an attorney.
- **Financial**: Free 30-minute telephonic consultation with a qualified specialist on issues such as debt counseling or planning for retirement.
- **Child Care:** Resources and referrals for child-care providers, before and after-school programs, camps, adoption organizations, and information about parenting and prenatal care.
- **Senior Care:** Resources and referrals for home-health agencies, assisted-living facilities, social and recreational programs, and long-distance caregiving.
- **Identity Theft:** 60-minute free consultation with a fraud-resolution specialist.
- **Pet Care:** Resources and referrals for veterinarians, pet-sitting resources, obedience training, pet stores.

ONLINE FEATURES INCLUDE:

- Interactive tools
- Educational materials
- Self-search provider locators
- Email for consultant assisted search
- Live messaging for consultant assisted search
- Web seminars

HEALTH AND WELLNESS
VOLUNTARY PROGRAMS

For our participants in the Premier, Basic, and Core Plans

The **Cigna HealthCare 24-Hour Health Information Line** is available day or night for people who need information on a wide variety of health-related topics. Callers can speak directly and confidentially with a trained nurse, or they can listen to prerecorded information on topics ranging from aging and women's health to nutrition and surgery.

Cigna's **online health assessment** helps people identify potential **health risks**. Based on responses individuals provide to questions about health and behavior, the system produces a wellness score and a report that tells people what they're already doing well and suggests steps they could take to improve their health.

Your Health First is MILA/Cigna's **chronic condition management** program that takes a unique approach to help people who have ongoing conditions such as:

- **Heart disease**
- **Asthma**
- **Chronic obstructive pulmonary disease (emphysema and chronic bronchitis)**
- **Diabetes Types 1 and 2**
- **Metabolic syndrome/weight complications**
- **Osteoarthritis**
- **Low back pain**
- **Anxiety**
- **Bipolar disorder**
- **Depression**
- **Weight Complications**

ENROLLMENT AND PROOF OF DEPENDENT STATUS

All members/participants who wish to cover their eligible dependents (spouse or children) must provide documentation verifying the eligibility of their dependents before the dependents will be enrolled in coverage (the *documentation must accompany the enrolment form*). A list of appropriate documentation which will establish eligibility by dependent category is listed below:

For the Employee

- A copy of the employee's Social Security Card
- A copy of the employee's birth certificate
- A copy of the employee's Medicare Card, if applicable
- An executed MILA Verification Form, containing data on the employee and other eligible dependents at the time it was completed together with supporting documentation

For the Spouse

- A copy of the spouse's Social Security Card.
- A copy of the spouse's Medicare Card, if applicable
- A copy of the spouse's birth certificate
- Other Insurance: for example, Blue Cross/Blue Shield, etc.
- A copy of the Marriage Certificate (In the case of a marriage in which a marriage certificate has been issued, a copy of that marriage certificate must be sent to MILA within 31 days of marriage)
- In the case of "common law" marriage in states which recognize such marriage: An affidavit attesting that (1) the two persons have met each of the standards which the state requires to qualify and (2) the two persons affirm that they are married.
- In the case of divorce, a copy of the final decree of divorce.

For Each Child

- A copy of each child's Social Security Card
- A copy of each child's birth certificate (parents' names must be listed)
- A copy of the Medicare Card for a disabled child or a child with renal failure, if applicable
- In the case of a natural child or a stepchild, a copy of the birth certificate in which the employee or the spouse is listed as a parent.
- In the case of an adopted child, a copy of the adoption agreement or, if the child was placed for adoption before the final adoption proceedings, a copy of the placement order from a court of competent jurisdiction. In the latter case, when final adoption occurs, a copy of this documentation must also be forwarded to MILA.
- In the case of a child under LEGAL GUARDIANSHIP, a copy of the court order or other legal order from an agency or court with jurisdiction.
- For an eligible disabled child who was a covered person under this plan or a predecessor plan who has attained the age of 26:

For Each Child (Continued)

- Proof (tax returns) that the child is dependent on the participant for support and maintenance;
- Proof that the child is incapacitated. This means that the child meets the following conditions:
    - A dependent is incapable of self-sustaining employment by reason of a mental or physical disability which began prior to the attainment of age 26.
    - Statements from a physician qualified to assess the child's condition should be obtained for the initial determination and periodically thereafter. All such statements should go to MILA.
- If applicable, a copy of a Qualified Medical Child Support Order (QMCSO) from a court of competent jurisdiction or a National Medical Support Notice (NMSN) issued by a state agency or a court of competent jurisdiction that requires that coverage be provided.

SPECIAL ENROLLMENT

Adding a New Dependent

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents. However, you must request enrollment within 5 months (150 days) after the birth, adoption or placement for adoption of a child or within 31 days of the marriage. If you enroll your dependent(s) within these timeframes, coverage will be retroactive to the date of the event. Otherwise, you may still enroll your new dependent(s), but coverage will not begin until you enroll him or her and the Fund Office receives your completed enrollment form.

You and your dependents may also enroll in this Plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage or become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after (1) the Medicaid or CHIP coverage ends or (2) you (or your dependents) are determined to be eligible for such assistance.

If you do not request enrollment within the above time frames, you may enroll later. However, your coverage will not be effective until the first of the month following the month in which the MILA Office receives your completed enrollment form and any applicable documentation. To request special enrollment or obtain more information, contact the MILA Office.

Remember, your dependents will not be eligible for coverage until you enroll them. This could mean that claims could be rejected and you will be responsible for any claims that were incurred during the time that your dependents were not properly enrolled in the MILA National Health Plan.

Obtaining Coverage – After having previously Declined MILA Coverage

If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). In order to be entitled to this special enrollment, you must complete and notarize the "Notice to Cancel All Benefits" form and return it to MILA along with proof of enrollment in other group health plan coverage when you seek to enroll in MILA.

When you or your dependents lose eligibility for other health coverage, you must request enrollment in the MILA Health Plan within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). You will be required to provide proof of loss of the other group coverage.

If you do not complete the enrollment process within 60 days, you or dependents will not be able to enroll in the Plan until the first day of the next calendar year. In order to obtain benefits for the next calendar year, you are required to request enrollment no later than thirty (30) days before the end of the current calendar year.

RECESSION OF COVERAGE

The Fund reserves the right to terminate your and your dependents' group health coverage prospectively for cause without notice (as determined by the Board or its delegees), or if you or your dependent are otherwise determined to be ineligible for coverage under the Plan. In addition, if you or your dependent commits fraud or intentional misrepresentation on an enrollment form, in connection with a benefit claim or appeal, or in response to any request for information by the Plan (including any Claims Administrator), or for failing to cooperate with the Plan's subrogation requirements, your coverage may be terminated retroactively (i.e., rescind your coverage) upon 30-days notice.

Failure to inform any such persons that you or your dependent is covered under another group health plan or knowingly withholding or providing false information in order to obtain (or continue) coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan.

A participant's or dependent's coverage may also be terminated retroactively (without notice) due to a failure to timely pay any premiums or self-pay contributions, including COBRA premiums. This means that the Plan may retroactively terminate coverage without notice in the event of the participant's legal separation/divorce or a child ceasing to meet the definition of child.

If coverage is terminated retroactively, you may be required to repay to the Fund amounts incorrectly paid by the Plan. The Board of Trustees may commence legal action against a participant or other individual for restitution and hold them liable for all costs of collection, including interest and attorneys' fees. The Board of Trustees may also offset future claim payments with respect to the participant or dependent to recover amounts owed.

COBRA CONTINUATION OF COVERAGE REMINDER

In compliance with a federal law referred to as COBRA Continuation Coverage, this Plan offers participants and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events). Qualified beneficiaries are entitled to elect COBRA when a qualifying event occurs. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events include termination of employment or reduction in hours of work making the participant ineligible for coverage, the death of the participant, divorce/legal separation, or a child ceasing to be an eligible dependent child. The maximum period of COBRA coverage is generally either 18 months (for loss of coverage resulting from termination of employment or reduction in hours of work) or 36 months (for loss of coverage resulting from death of the participant, divorce/legal separation, or a child ceasing to be an eligible dependent child), depending on which qualifying event occurred.

However, MILA has determined that ALL qualified beneficiaries (including covered employees) are entitled to elect COBRA coverage for a maximum of 36 months, regardless of the qualifying event causing the loss of coverage.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, you and/or a family member must inform the Plan in writing of that event no later than ***60 days after that event occurs***.

That notice must be in writing and must be sent to the Fund Office via first-class mail and is to include the participant's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents). If you fail to notify the MILA Plan Office within 60 days of the event, coverage will terminate as of the date of the event and your dependents will have no right to COBRA coverage.

When your coverage terminates, in addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may want to look for coverage through the Health Care Marketplace (see https://www.healthcare.gov/). In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

If you have questions about this notice requirement or any aspects of COBRA continuation coverage, please contact the MILA Plan Office. For more information about your rights under the Employee Retirement Income Security Act (ERISA), COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayment, and coinsurance applicable to other medical and surgical benefits. These provisions are generally described in the Plan's Summary Plan Description (SPD). If you have any questions about the coverage of mastectomies or reconstructive surgery, please contact Cigna (at the phone number listed on your ID card) or the MILA Plan Office.

NEWBORN'S AND MOTHERS' HEALTH PROTECTION ACT NOTICE REMINDER

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.
However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of staying longer than 48 hours for a vaginal birth or 96 hours for C-section, contact Cigna at the number on your ID card. If you have questions about this Notice, contact the MILA Plan Office.

MANDATORY NOTIFICATION OF DIVORCE

The MILA Trustees have instructed the MILA staff to remind MILA participants who are married that in the event the participant gets divorced, the participant **MUST immediately notify both MILA and his or her local welfare fund that he or she is divorced.** In addition, the participant must immediately provide both MILA and the local welfare fund with a copy of the official document that memorializes the divorce.

The Trustees also want to remind the participants that if any participant fails to notify MILA and the local welfare fund about the divorce immediately after the divorce occurs, the participant will be responsible for any claims paid by MILA for the ex-spouse and any other dependents, such as step-children, who are no longer eligible for MILA benefits as a result of the divorce. In addition, any MILA participant who fails to notify MILA and the local welfare fund about his or her divorce immediately after the divorce occurs **can have their MILA benefits suspended if any claims for ineligible persons are paid by MILA** and the participant fails to reimburse MILA for the ineligible claims which MILA paid.

The Trustees want to remind all participants that when MILA pays for ineligible claims, that reduces the funds that are available to protect the MILA participants and their families.

ADDITIONAL INFORMATION AND UPDATES TO THE SPD

Where to Find Plan Documents

The easiest way to access documents is from the Plan's Website at www.milamhctf.com. There you can find important Plan documents, including the Summary Plan Description (SPD), Summary of Material Modifications (SMM), Summary of Benefits and Coverage (SBCs), forms, contact information, and other important information. You may also request a paper copy of plan documents and other notifications by calling the MILA Plan Office.

Collective Bargaining Agreement

This Plan is maintained under Article XIII of the collective bargaining agreement between the United States Maritime Alliance, Ltd. ("USMX") and the International Longshoremen's Association, AFL-CIO ("ILA"). A copy of that agreement may be obtained by Plan participants upon written request to the Plan Administrator and is available for examination by Plan participants.

Keep the MILA Plan Office Informed of Address Changes

To protect your family's rights and privacy, make sure to let the MILA Plan Office know about any changes in addresses. Remember, in order to update or change your address; you must do so in writing by completing the appropriate address change form. You may request an address change from the MILA Plan Office. You should also keep a copy of any notices you send to MILA for your records.

INFORMATION FOR OUR RETIREES

Medicare Enrollment/Eligibility in the MILA National Health Plan for Pensioners

If you are a Pensioner, the spouse of a Pensioner, or another dependent of a Pensioner and you do not have other coverage by virtue of active employment and you are eligible to enroll for Medicare, you **must enroll in and keep** Medicare Parts A & B in order to have complete benefits in MILA.

Benefits that are paid for by this Plan for Medicare-eligible individuals are reduced by the amounts payable under **Medicare Parts A (Hospital)** and **B (Medical)**. This reduction will apply even if a Medicare-eligible individual is NOT enrolled in Medicare Parts A and B; therefore, if you are Medicare-eligible, you must enroll in Medicare Parts A and B in order to receive the maximum amount of benefits under this Plan.

Complete information regarding Medicare benefits and how to enroll may be obtained from your local Social Security office.

MILA provides prescription drug coverage which is Creditable Coverage; that is, it is comparable to or better than Medicare Part D coverage. **Do not sign up for any other Medicare Part D coverage or you will lose your MILA prescription benefits!**

To find out more about Prescription Drug Benefits and Medicare, you should review the Plan's Medicare Part D Notice of Creditable Coverage which is available from the MILA Plan Office.

Medicare Part B Annual Deductible

Your annual deductible under MILA will match the Medicare Part B Annual Deductible that is set by the Centers for Medicare & Medicaid Services (CMS) each year. Please refer to your Medicare and You Book for an annual deductible or visit Medicare.gov or call 1-800-MEDICARE to get specific cost information. The "**Medicare** & **You**" handbook is mailed to all **Medicare** households each fall.

NEW MEDICARE CARDS

As a reminder, your new card will have a new Medicare Number that's unique to you, instead of your Social Security Number. This will help to protect your identity.

See an example of the new Medicare card below.

For more information on how your Medicare Plan works, see your **Medicare and You Handbook or** contact Medicare at 1-800-Medicare (1-800-633-4227 or visit their site at https://www.medicare.gov

☞IMPORTANT WARNING ☜

For active MILA members who are already enrolled in MEDICARE (at age 65, Disabled or end-stage renal disease (ESRD) WHEN THEY START RECEIVING A PENSION

When an active MILA member who is eligible for MILA retiree benefits retires and starts receiving a pension from the local pension plan:

- If the member is **already enrolled in Medicare** when the member leaves active service, the member must have both **Medicare Part A and Medicare Part B** coverage when the member's pension starts, and the member's MILA coverage is transferred to the MILA Medicare Wrap-around Plan. **(MEDICARE WILL BE THE MEMBER'S PRIMARY COVERAGE, AND MILA IS SECONDARY COVERAGE).**

- If the member's spouse is already enrolled in Medicare when the member starts receiving a pension, the Member's spouse must have both **Medicare Part A and Medicare Part B** in order to be eligible for the MILA Medicare Wrap-around Plan.

For active MILA members who are eligible for Medicare (at age 65, Disabled or ESRD) WHEN THEY START RECEIVING A PENSION

If the member/spouse is eligible for Medicare when the member starts receiving a pension and either the member or spouse does not have **Medicare Part A and Medicare Part B** coverage:

- The member/spouse must sign up for **Medicare Part A and Medicare Part B**

- If the member/spouse has **Medicare Part A** but does not have **Medicare Part B,** when MILA pays the member's or spouse's medical bills under the MILA Medicare Wrap-around Plan, the payment will be based on the assumption that the member/spouse has **Medicare Part B coverage.**

- If the member/spouse does not have **Medicare Part B** coverage, the member/spouse will be billed for the amount that would have been paid by the **Medicare Part B** coverage. These bills for the amount that would have been paid by the **Medicare Part B** coverage are the member's or spouse's responsibility. MILA **WILL NOT** pay these bills.

According to medicare.gov, the official U.S. Government site for Medicare:

In most cases, if you don't sign up for Medicare Part B when you're first eligible, you'll have to pay a late enrollment penalty. You'll have to pay this penalty for as long as you have Part B and you could have a gap in your health coverage.

Between January 1–March 31 of each year: You can sign up for **Medicare Part A and/or Medicare Part B** during the General Enrollment Period between January 1–March 31 of each year, if both of these conditions apply:

- You didn't sign up for Medicare Part A and Part B when you were first eligible.
- You aren't eligible for a Special Enrollment Period (see below).

You must pay premiums for Part A and/or Part B. Your coverage will start July 1. You may have to pay a higher premium for late enrollment in Part A and/or a higher premium for late enrollment in Part B.

DISCRIMINATION IS AGAINST THE LAW

The MILA Managed Health Care Trust Fund ("MILA") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MILA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The MILA Managed Health Care Trust Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact La Verne Thompson (contact information listed below).

If you believe that MILA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

LaVerne Thompson, Executive Director
HIPAA Privacy and Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, Suite 502
New York, New York 10006-1901
Tel: 212-766-5700
Fax: 212 766-0844/45
E-mail: info@milamhctf.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, LaVerne Thompson is available to help you.

You can also file a civil-rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Telephone: 1-800-368-1019
TDD: 800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

IMPORTANT NOTICE & REMINDER

Re: Medical Treatment for On-The-Job Injuries

This notice is being sent to you in order to bring to your attention the proper procedure for obtaining medical treatment for on-the-job injuries under your MILA coverage. As an active longshore employee working at a port that is covered by the Management-ILA Managed Health Care Trust Fund a/k/a MILA, you may be granted medical coverage.

If you are injured on the job, your employer is required by law to pay for medical treatment you need to treat your injury. However, if your employer does not pay or controverts the treatment, MILA may advance the payment for your treatment under limited circumstances provided that there is compliance with all procedures as determined solely by MILA. This creates a problem for both MILA and you.

The Problem for MILA

The problem for MILA is that MILA is paying claims for which it is not responsible. This wastes MILA's assets instead of preserving MILA's money to pay claims for you, your family members, and the other eligible MILA members for which MILA is responsible.

The Problem for You

If MILA pays for your treatment instead of your employer, under MILA's subrogation or reimbursement policy you are required to repay any monies which MILA paid on your behalf. Subrogation is MILA's right to recover any money MILA spent paying claims related to your injury if you successfully pursue a claim against your employer under the Longshore and Harbor Workers Compensation Act (LHWCA) or a state worker's compensation law or any liable third party. MILA's right to be repaid comes before your right to receive any recovery under those laws.

For example:

Assume you are injured on the job and MILA pays $20,000 for medical care to treat your injury. Your recovery in the claim against your employer or another third party will be reduced by $20,000 to repay MILA for the medical care you received to treat your injury that MILA paid on your behalf. In some cases where you recover money, if the monies owed to MILA are not repaid, your MILA benefits can be suspended until you have repaid MILA.

To avoid this problem, you should:

1) ensure that MILA does not pay the medical claims incurred on account of your work-related injury;

2) provide proper notice to your employer as to your injury and file the necessary worker's compensation claim documents;

3) inform your medical providers that your injury is work-related;

4) as soon as possible after being injured, provide MILA with all information as to what injuries are involved and who your medical providers are by calling MILA at (212-766-5700), sending an email to (laverne@milamhctf.com), or sending a fax to (212-766-0844); and

5) provide a copy of any and all state or federal worker's compensation claim documents, which you should receive from the employer and/or carrier, including but not limited to the *Notice of Employee's Injury or Death* (LS-201), *Employer's First Report of Injury* (LS-202 or WC-1), *Notice of Controversion of Right to Compensation* (LS-207 or WC-3) by email to (laverne@milamhctf.com) or fax (212-766-0844).

As the above list of the steps that you must take makes clear, the key to avoiding subrogation is to make sure that MILA knows as soon as possible that you have suffered a work-related injury.

WHEN EMPLOYER CONTROVERTS CLAIM

Finally, let's talk about the situation where an employer claims that an injury is not work-related. In such a case, if the employer denies responsibility, MILA will advance the cost of your medical treatment. For this to happen, you must first notify MILA of the claim and of your employer's denial or controversion of the claim. As a condition of providing coverage, MILA will require you to execute a MILA Lien Form.

MILA may also require you to sign a Reimbursement Agreement, which will be provided at the appropriate time. The Lien Form and the Reimbursement Agreement protect MILA's right to recover the amount that it pays on your behalf in the event you file a LHWCA claim or other type of worker's compensation claim against your employer or a third party and you are successful. If your employer prevails on its claim that your injury is not work-related, you will not be required to repay benefits paid by MILA on your behalf.

In the event the employer controverts your claim and the case is eventually settled, MILA will review the terms of the settlement to determine the amount it will require you to repay.

If you have any questions about this letter or how subrogation works, please contact MILA.

MILA TRUSTEES

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Association
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Philadelphia, PA 19125

ATTENTION: FREE LANGUAGE ASSISTANCE

This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.

Language	Message About Language Assistance
1. Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
2. Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 CIGNA 1-800-794-7882/ CVS Caremark 1-866-875-6452
3. French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
4. Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
5. German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
6. Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
7. Persian	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452 تماس بگیرید
8. Hindi	ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452 पर कॉल कर।
9. Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
10. Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452 번으로 전화해 주십시오.
11. Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
12. Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
13. Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452 まで、お電話にてご連絡ください。
14. French Creole (Haitian)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
15. Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
16. Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
17. Gujarati	ચુના: જો તમે જરાતી બોલતા હો, તો િન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
18. Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
19. Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទCIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
20. Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452

Managed Health Care Trust Fund Privacy Notice

Section 1: **Purpose of This Notice and Effective Date**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective date. The effective date of this Notice was April 14, 2003. This Notice has been revised as of September 23, 2013.

This Notice is required by law. The MILA Managed Health Care Trust Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the United States Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Plan's privacy practices.

Section 2: **Your Protected Health Information**

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or for payment for health care. PHI includes information maintained by the Plan in oral, written, electronic or any other form.

When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

- ***At your request***. If you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect and/or copy it.
- ***As required by an agency of the government***. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- ***For treatment, payment or health care operations***. The Plan and its business associates will use PHI in order to carry out:

➢ Treatment,
➢ Payment, or
➢ Health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

Health care operations include but is not limited to quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

The Plan must generally obtain your authorization before each of the following (each of these includes defined exceptions under which the Plan uses or disclose your PHI for these purposes without your authorization):

- Using or disclosing psychotherapy notes about you from your psychotherapist.
- Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.
- Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan is not likely to have access to or maintain these types of notes.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose without your written consent or authorization is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and

- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Please contact the Fund's Privacy/Security Officer if you wish to limit access to your PHI by any of the persons described above.

Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required

The Plan is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. ***When required by law.***

2. ***Public health purposes.*** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition if authorized by law.

3. ***Domestic violence or abuse situations.*** When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to minor's PHI.

4. ***Health oversight activities.*** To a public health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. ***Court proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided that certain conditions are met, including that: (a) the requesting party must give the Plan satisfactory assurances a good faith attempt has been made to provide you with written notice, and (b) the notice provided sufficient information about the proceeding to permit you to raise an objection, and (c) no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).

7. ***Law enforcement emergency purposes.*** For certain law enforcement purposes if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan, in its best judgment, determines that disclosure is in the best interest of the individual. Law enforcement includes:

a. identifying or locating a suspect, fugitive, material witness or missing person, and

b. disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8. ***Determining the cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties.

9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.

10. ***Research.*** For research, subject to certain conditions.

11. ***Health or safety threats.*** When consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Other Uses or Disclosures

The Plan may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Plan may disclose protected health information to the sponsor of the Plan for reasons regarding the administration of this Plan. The "plan sponsor" of this Plan is the MILA Managed Health Care Trust Fund Board of Trustees.

Any other Plan uses, and disclosures not described in Section 2 of this notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization.

Section 3: Your Individual Privacy Rights

Breach Notification

If a breach of your unsecured PHI occurs, the Plan will notify you.

You May Request Restrictions on PHI Uses and Disclosures

You may request the Plan to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request.

You should make all requests to the Privacy/Security Officer at:

LaVerne A. Thompson, Executive Director
And HIPAA Privacy/Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, Suite 502
New York, NY 10006

You May Request Confidential Communications

The Plan will accommodate an individual's reasonable request to receive communications of PHI **by alternative means or at alternative locations** where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Privacy/Security Officer at the above address.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you and the Plan will honor that request to the extent possible. You also may request a summary of your PHI.

The Plan must provide the requested information within 30 days. A single 30-day extension is allowed if the Plan is unable to comply with the deadline, and if the Plan provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable cost-based fee for creating or copying the PHI or preparing a summary of your PHI may be charged. Requests for access to PHI should be made to Privacy/Security Officer at the address on page 33.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and U.S. Department of Health and Human Services.

Designated Record Set: includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analysis and not used to make decisions about you is not included.

You Have the Right to Amend Your PHI

You have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Plan's Right to Amend Policy for a list of exceptions.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend the PHI to the Privacy/Security Office at the address and phone number found on page 33.

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of certain disclosures by the Plan of your PHI during the six years before the date of your request. However, such accounting need not include PHI disclosures made: (a) to carry out treatment, payment or health care operations or (b) to you or authorized by you in writing; or (c) before the privacy rule compliance date.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy/Security Officer at the address and phone number found on page 33. This right applies even if you have agreed to receive the Notice electronically.

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action on your behalf.

Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form or may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public.
- A court order of appointment of the person as the conservator or guardian of the individual.
- The status of the personal representative as the parent of a minor child.

You may obtain this form by calling the Fund Office.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Plan will automatically consider a spouse to be the personal representative of an individual covered by the Plan. Disclosures under this provision will be limited to verification of coverage and claims status. In addition, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable law requires otherwise.

A spouse or a parent may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Plan restrict information that goes to family members. Such request will be governed by the provision entitled **You May Request Restrictions on PHI Uses and Disclosures**, which appears at the beginning of Section 3 of this Notice.

Section 4: The Plan's Duties

Maintaining Your Privacy

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of the Plan's legal duties and privacy practices. In addition, the Plan may not (and does not) use your Genetic Information that is PHI for underwriting purposes.

This notice is effective April 14, 2003 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date.

If a private practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI. All notices will be mailed to the participant's address on record.

If material changes are made to this Notice it will be posted on the Plan's website no later than the effective date of the revision and thereafter sent in the Plan's next annual mailing.

Material changes are changes to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Disclosures to the Plan Sponsor (Board of Trustees)

As described in the amended Plan document, the Plan may share PHI with the Plan Sponsor (Board of Trustees) for limited administrative purposes, such as information compiled for MILA's Third Party Administrators in connection with determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these administrative functions.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of:

LaVerne A. Thompson, Executive Director
And HIPAA Privacy/Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, Suite 502
New York, NY 10006

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services ("HHS"). Filing instructions are available at http:www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

The Plan may not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the HIPAA Privacy/Security Officer.

Section 7: Conclusion

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules in 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.