MILA MANAGED HEALTH CARE TRUST FUND

November 14, 2014

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, Benjamin 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 2013 annual financial filing with the government.
- The Summary of Material Modifications for 2014, which outlines the significant changes/clarifications in the Plan's benefits adopted during 2014.
- Grandfathered Health Plan Notice.
- An Annual Notice of certain benefits offered by MILA, as required by the Women's Health and Cancer Rights Act of 1998.
- Important Reminders .
- MILA Privacy Notice.

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

Enc.
cc: MILA-MHCTF Trustees
Local Port Administrators
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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, 2013. 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 $832,218,794 as of December 31, 2013, compared to $807,476,901 as of December 31, 2012. During the plan year the plan experienced an increase in its net assets of $24,741,893. 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 $491,659,694, including employer and other contributions of $385,588,123, losses on the sale of assets of $6,577,196, and unrealized gains from investments and interest income of $72,467,231. Plan expenses were $466,917,801. These expenses included $4,841,462 in administrative expenses, and $462,076,339 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
MILA Managed Health Care Trust Fund National Health Plan
Plan Changes Adopted During Plan Year 2014

The current Summary Plan Description (SPD) for the MILA National Health Plan describes benefits that were payable under the Plan on June 1, 2008. At the end of 2008, 2009, 2010, 2011, 2012 and, 2013, Summaries of Material Modifications (SMM) were published describing changes to the Plan effective since the publication of the SPD. This Summary of Material Modifications describes Plan changes that were effective after publication of the last SMM in 2013.

AFFORDABLE CARE ACT (ACA) - IMPORTANT INFORMATION

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. 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 not a Grandfathered Plan. 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.

MILA Plan Changes

MILA Disability Credited Hours - Effective October 1, 2014

MILA disability credited hours based on the receipt of Workers Compensation benefits or non-occupational disability benefits provided by a local port plan shall be limited to twenty-four (24) months per illness or injury. The 24 month limit is a per illness or injury limit, not a lifetime limit. When a participant has exhausted the 24 months, the participant may submit applications to MILA on an annual basis to receive additional years of credited service.

The twenty-four (24) month per illness or injury limit for disability-credited hours began on October 1, 2014. Anyone who had received MILA disability credited hours through September 30, 2014, will retain those hours.

Effective October 1, 2014, no one can receive a total of more than twenty-four (24) months of disability credited hours per illness or injury based on the receipt of Workers Compensation benefits or non-occupational disability benefits provided by a local port plan unless the person has submitted in writing a request for an application to MILA to receive up to an additional year of credited service and MILA has approved the extension.

The decision by MILA is final and binding with no right of appeal. The per illness or injury limit of twenty-four (24) months will include disability credited hours received before October 1, 2014 and after October 1, 2014. In order to receive additional years of credited service beyond the first year, annual applications must be submitted to and approved by MILA.

IMPORTANT REMINDER: Any MILA participant who is receiving Social Security Disability Income (SSDI) benefits cannot receive credited hours based on the receipt of accident and health benefits or the receipt of Workers Compensation benefits or non-occupational disability benefits.

MILA Disability Pensioner Benefits – Effective October 1, 2014

1. On and after October 1, 2014, when a disabled pensioner who is receiving a disability pension from a local port applies to MILA for MILA disability pensioner benefits, he or she must submit proof to MILA that he or she has submitted an application to the Social Security Administration to receive Social Security Disability Income (SSDI) benefits. In addition, the disabled pensioner must submit to MILA within one week of receipt a copy of any correspondence which he or she receives from Social Security in connection with the application for SSDI benefits.

2. While the SSDI application to the Social Security Administration is pending, MILA will continue to provide MILA benefits to the applicant pursuant to the practice between MILA and the local port. The applicant will receive the MILA plan the applicant is covered by at the time he or she applies for MILA disability pensioner benefits, unless at the time of his or her application for MILA disability pensioner benefits he or she has enough credited hours to receive a better MILA plan, in which case he or she will receive the better MILA plan on January 1 of the following year, provided his application for SSDI benefits is pending.

Please Note: Within thirty (30) days after his or her application to the Social Security Administration, the applicant must provide to MILA a copy of the **Social Security Administration Retirement, Survivors and Disability Insurance Notice Award letter.**

3. If an applicant does not qualify for SSDI benefits, he will not be eligible for MILA disability pension benefits. However, if an applicant does not qualify for SSDI benefits, he may request a review of his condition by submitting in writing a request for an application to MILA. An applicant must apply to MILA within thirty (30) days after his application (and any appeals) for SSDI benefits is denied. The applicant will continue to receive MILA benefits while MILA reviews the case. MILA will determine whether the applicant is disabled for purposes of performing longshore work. Each case submitted to MILA will be subject to review by the MILA Board of Trustees (or any committee created by the Board of Trustees), to determine whether the applicant is qualified to receive MILA disability pensioner benefits. Any decision reached by the MILA Trustees or any committee acting on the Trustees' behalf, will be final and binding and not subject to any review or appeal.

MILA Coverage for Employer Association Retirees

1. The employer association retiree must be receiving a defined benefit pension based upon his employment in the industry. If the retiree is not receiving a defined benefit pension, he must be entitled to participate in a company sponsored retirement plan.

2. If the employer association retiree is at least age 58 years old when he retires, he will qualify for MILA Basic plan benefits provided he has at least twenty-five (25) years of service in the longshore industry and he has worked at least five (5) years with the association immediately before his retirement. At age 62, he will receive MILA Premier plan benefits and at age 65 or eligibility to enroll in Medicare, if earlier, he will receive MILA Medicare Wrap-Around benefits.

3. If the employer association retiree is at least 62 years old when he retires, he will qualify for MILA Premier plan benefits provided he has at least twenty-five (25) years of service in the longshore industry and he has worked at least five (5) years with the association immediately before his retirement. At age 65 or eligibility to enroll in Medicare, if earlier, he will receive MILA Medicare Wrap-Around benefits.

4. If the employer association retiree is at least age 65 years old when he retires, he will qualify for MILA Medicare Wrap-Around benefits provided he has at least ten (10) years of service in the longshore industry and he has worked at least five (5) years with the association immediately before his retirement.

5. The term "in the longshore industry" includes employment in (a) any company that was a signatory to a deep-sea collective bargaining agreement covering ports in the United States, except Alaska and Hawaii, or (b) any company bound by the terms of any deep-sea collective bargaining agreement covering ports in the United States, except Alaska and Hawaii, with a multi-employer bargaining association by reason of being a member of such association.

6. Any employer association retiree receiving MILA retiree benefits shall no longer be eligible to receive MILA benefits if the retiree goes to work for an employer in an employment classification in which health care benefits are made available.

7. If the employer association stops covering active employees in MILA, the employer association retiree(s) who were receiving MILA benefits shall no longer be eligible for MILA benefits.

MILA Survivor Benefits If An Active Participant Dies

If a MILA participant dies, the surviving spouse and children will receive the MILA benefits that the deceased participant was receiving at the time of death, provided that at the time of the participant's death, the participant was (1) working on a job for which the $5.00 man-hour contribution was paid to MILA; (2) the participant was receiving MILA benefits at the time of his or her death; and (3) the participant would have been eligible for a disability pension based on his or her age and years of service in the port at the time he or she died. The benefits will be provided pursuant to the terms of the MILA plan. If any port has discontinued disability pensions, the participant who dies will be entitled to MILA benefits if at the time of his or her death, he or she would have qualified for a disability pension under the rules in that port which were in effect before the port discontinued disability pensions.

IMPORTANT REMINDERS

Coverage for Adult Children

The Patient Protection and Affordable Care Act (the Act and subsequent Health Care and Education Reconciliation Act referred to herein collectively as "PPACA" or "Affordable Care Act" or "ACA") requires group health plans offering dependent coverage to extend such coverage until dependents reach age 26 (referred to herein as "adult dependents"). The provision affected MILA beginning in 2011. Because the plan is grandfathered, the provision only applied during 2011 through 2013 if the adult dependent had not been offered other employer-sponsored coverage. After January 1, 2014, the adult dependent must be offered coverage regardless of access to other employer-sponsored coverage. If you wish to cover your Adult Children, you must enroll those Adult Children for such coverage in MILA beginning in 2014 if they are not currently covered.

Health Insurance Marketplace

Through the Affordable Care Act, Health Insurance Marketplaces (formerly known as the Health Insurance Exchanges) have been established across the country that will allow individuals and employers to easily compare and evaluate health insurance coverage and to obtain that coverage beginning in 2014. A Marketplace has been set up in every state, some run by the state and others by or in partnership with the federal government. If you lose coverage in MILA, you may be eligible to enroll for coverage in your State's Health Insurance Marketplace. For more information, please visit www.healthcare.gov/health-insurance-marketplace/.

Affordable Care Act (ACA) Notice and 90-Day rule.

Longshore persons who have not been covered in MILA during 2014 because they did not earn a sufficient number of credited hours during the contract year ending 09/30/2013 but do qualify for MILA coverage in 2015 based upon credited hours earned during the contract year ending 09/30/2014 will be subject to new rules as to when their coverage will begin. Coverage will begin on the earlier of (1) the beginning of the month that is 13 months from the month in which they earned their first credited hour during the contract year and (2) 90 days from the end of the contract year.

For example:

- A person who earns his/her first credited hour during October 2013 and earns at least 700 credited hours during the contract year ending September 30, 2014 will have coverage begin on 11/01/2014.
- A person who earns his/her first credited hour during November 2013 and earns at least 700 credited hours during the contract year ending September 30, 2014 will have coverage begin on 12/01/2014.
- A person who earns his/her first credited hour during December 2013 or after and earns at least 700 credited hours during the contract year ending September 30, 2014 will have coverage begin on 12/30/2014.

A person who is covered in MILA during 2014 and who earns at least 700 credited hours during the contract year ending September 30, 2014 will not be affected by this provision. The MILA Plan in which that person will be covered during 2015 will be determined by the total number of credited hours earned during the contract year ending September 30, 2014.

URGENT CARE vs. EMERGENCY ROOM (ER) CARE

Next time you need medical attention, consider your options!

Illness 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, etc.

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, sore throats, sprains and strains, minor burns/small cuts, rashes, nausea, migraines, conjunctivitis (pink eye), bladder/urinary symptoms, etc.

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.

LOOK WHAT'S NEW UNDER CVS/CAREMARK

CVS/caremark

Add email@rxhealthinfo.com to your address book
View in web browser

Scan to Refill by Mail with Your Smartphone

Look what you can do with our CVS Caremark mobile app. Sign up at Caremark.com to fill your long-term medicine in 90-day supplies by mail rather than 30-day supplies at your pharmacy.

DOWNLOAD APP NOW

Then use your phone to scan the bar code or QR code on your mail service Rx for instant refill. Simply use our app to scan anytime and we mail your refills automatically. No more monthly refill calls or trips to the pharmacy!

Manage your prescription medicine on the go with these tools for all CVS Caremark mobile app users:

Easy Refill - Request or scan for a refill anywhere, anytime.

Pill Identifier - Quickly identify over-the-counter pills with a simple scan.

Drug Interactions - Avoid unwanted interactions between medicines.

Members who sign in through our app can access more features like:

- Check Drug Costs for Savings Opportunities
- Find a Pharmacy
- Orders & History

CVS CAREMARK ALSO OFFERS TO ALL OUR ELIGIBLE MEMBERS

Blood Glucose Meter:

Do you have diabetes? You may qualify for a blood glucose meter at no cost to you!

How do you qualify for this offer?

- Have diabetes
- Have MILA/CVS Caremark Mail Service prescription benefits
- Use ACCU-CHEK or OneTouch test strips that are covered by the CVS Caremark Mail Service

The following blood glucose meter kits are currently offered:

- Roche ACCU-CHEK Aviva
- Roche ACCU-CHEK Compact Plus
- LifeScan OneTouch UltraSmart
- LifeScan OneTouch UltraMini

To see if you qualify for a blood glucose meter at no charge, please contact the CVS/ Caremark Diabetic Meter Team toll-free at 1-800-588-4456 or by calling the phone number on the back of your MILA CVS/Caremark I.D. card.

Caremark.com - Mobile Web Site

You can now manage your prescription needs from your cell phone or your iPhone/ iPad/Android. This site provides users of cellular devices a more efficient way to:

- **Refill Mail Service Prescriptions**
- **Request a New Prescription**
- **View Prescription History**
- **Check Order Status**
- **Check Drug Coverage and Cost**
- **Find a Pharmacy**
- **And more!**

No matter how or where you access the site, your information is saved in real time, so it's always up to date. The best part is it is free! Simply visit Caremark.com from your mobile Web device and register or log in to get started.

INFORMATION FOR OUR MEDICARE BENEFICIARIES

MEDICARE ENROLLMENT/ELIGIBILITY

If you are **not a pensioner** and your coverage in MILA is due to the hours you have earned in the previous contract year or due to your active employment with an Employer that has signed a Participation Agreement, you are not required to enroll in Medicare. However, if your dependent does enroll in Medicare, MILA will be the primary payer of your dependents benefits and Medicare benefits will be secondary. Medicare will determine any benefits payable by Medicare after considering all benefits payable by MILA.

If **you are a pensioner**, the spouse of a pensioner, or other 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. 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, comparable 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!**

Below is a summary of the benefits available in the MILA Medicare Wrap-Around Plan

SUMMARY OF THE MILA MEDICARE WRAP-AROUND PLAN	
Who Is Eligible For Coverage	Regular Pensioners and their dependents who are eligible to enroll in Medicare and who are not enrolled in a Medicare Advantage Plan
If eligible, must a person enroll in Medicare?	The covered person **must** enroll in Medicare, Part A and Part B. Generally, the person should not enroll in Medicare, Part D.
Which Plan pays first and controls - Medicare or MILA?	Medicare pays before MILA. If the expense is eligible for Medicare benefits, Medicare's rules apply. Otherwise, MILA's rules apply
What expenses are eligible for MILA reimbursement?	Generally, the Plan pays benefits based upon the person's Medicare deductibles and co-insurance expenses that remain after Medicare's payments.
What Benefits Will MILA Pay	
For Medicare, PART A	MILA will pay 100% of the Part A deductible and the portions of the hospital or nursing home expense, which are covered by Medicare but are the member's responsibility.
For Medicare, PART B	The first $150 of the Part B eligible expenses are the person's deductible ($300 per family) in a calendar year. Thereafter, the Plan pays 80% until the person's maximum out-of-pocket expense is reached. Thereafter, it pays 100% for the balance of the calendar year.
What Is The Person's Maximum Out-of-Pocket Expenses?	The person will pay no more than $2,500 in MILA deductible and co-insurance expenses during the calendar year (maximum $5,000 per family).
What Is The Plan's Maximum Benefit?	The MILA Plan will pay no more than $500,000 during a person's lifetime.
Plan Limitations and Exclusions.	**The Premier Plan's provisions which apply to out-of-network benefits also apply to this plan unless Medicare applies a benefit limit, in which case, the Medicare limit will apply.**
PRESCRIPTION DRUG BENEFITS	**The prescription drug benefits in this plan are the same as in the Basic and Premier Plans.**
Prescription Brand Deductible per Individual	**$500 Deductible applies to all Brand Name Drugs when a generic equivalent is available**
RETAIL	
Retail Copay - 30-day supply (Generic)	**$5**
Retail Copay - 30-day supply (Preferred Brand)	**$10**
Retail Copay - 30-day supply (Non-Preferred Brand)	**$25**
MAIL	
Mail Order Copay - 90 day supply (Generic)	**$5**
Mail Order Copay - 90 day supply ((Preferred Brand)	**$15**
Mail Order Copay - 90 day supply (Non-Preferred Brand)	**$50**

WOMEN'S HEALTH
AND
CANCER RIGHTS ACT OF 1998 NOTICE

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998.

In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

This coverage is subject to a plan's annual deductibles and coinsurance provisions. 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 your Local Port Administrator or the MILA office.

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 includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care 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 into 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 include 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 that 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 and objection, and (c) no objections were raised or the objection 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 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 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 19.

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 analyses 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 Officer at the address and phone number found on page 19.

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 19. 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 privacy 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 complied 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 Privacy/Security Officer
MILA Managed Health Care Trust Fund
111 Broadway, Suite 502
New York, NY 10006
1212-766-5700

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 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 at 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.