MILA MANAGED HEALTH CARE TRUST FUND

November 15, 2012

TO: All Eligible Participants

FROM: LaVerne Thompson, Executive Director

Season's greetings for a safe and healthy holiday season to you and your family from the MILA Co-Chairmen, Richard P. Hughes, 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 Summary Annual Report, which summarizes MILA's 2011 annual financial filing with the government.
- The Summary of Material Modifications for 2012, which outlines the significant changes/clarifications in the Plan's benefits adopted in 2011-2012.
- An Annual Notice of certain benefits offered by MILA, as required by the Women's Health and Cancer Rights Act of 1998.
- Important Reminders.
- Clarification For MILA Mental Health Program.
- MILA Privacy Notice.
- Early Retiree Reinsurance Program ("ERRP") Notice.
- Grandfathered Health Plan 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, 2011. 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 $762,613,158 as of December 31, 2011, compared to 720,706,330 as of December 31, 2010. During the plan year the plan experienced an increase in its net assets of $41,906,828. 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 $443,307,623, including employer and other contributions of $370,778,182, gains on the sale of assets of $7,777,221, and unrealized gains from investments and interest income of $29,478,343. Plan expenses were $401,400,795. These expenses included $4,473,331 in administrative expenses, and $396,927,464 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 2012

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 and 2011 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 and during 2012.

IMPORTANT REMINDERS

Coverage for Adult Children

As you are aware, effective January 1, 2011, your child (or children) who previously lost the right to MILA coverage may again be eligible. This change occurred because of the new rules for the coverage for children that were enacted under Health Reform – also known as the Patient Protection and Affordable Care Act (PPACA), which was signed into law by President Barack Obama. On January 1, 2011, the changes were as follows:

- The Plan must recognize only the child's relationship to the member as the basis for coverage rather than taking into consideration factors such as "financial support," "marital status" or "student status"; and
- The Plan must provide that coverage will be available up to the child's 26th birthday; but
- However, the Plan will provide that coverage will terminate on the date that the child is employed and has the right to elect medical coverage (regardless of whether the employer's plan is as good as the MILA plan). The Plan will reinstate coverage on the date the plan is notified that the child's right to employment related coverage ceased.

As a result of this change, the Plan will recognize as an eligible child any person who is (1) the natural child of the member, (2) the step child in the current marriage of the member, (3) a child for whom legal guardianship has been awarded to the member or (4) a child for whom coverage is required to be provided pursuant to an Adoption Agreement, a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). In the event of the divorce of a member, any children who are not the natural children of the member will no longer be covered by the Plan unless the children otherwise qualify for coverage.

The Trustees of MILA have agreed that children will remain eligible until the end of the month in which they attain age 26. **NOTE: Children will remain eligible until the attainment of age 26 as long as the member continues to be eligible for MILA benefits.**

CLARIFICATION OF THE MENTAL HEALTH PROGRAM

In December 2010, MILA distributed a brochure entitled "Your Wellness Plan." Included in the brochure was a chart that set forth the details of the coverage that MILA provides in the mental health program.

Unfortunately**, the chart included information**, which did not **accurately state the** correct **details of the plan** as the **plan is administered pursuant to the Mental Health Parity and Addiction Equity Act. In order to correct the errors**, set forth below are MILA's updated charts for the various plans under the MILA National Health Plan for your perusal.

SUMMARY OF THE MILA NATIONAL HEALTH PLAN: PREMIER BENEFITS		
	PREMIER	
Features	**In-Network**	**Out-of-Network**
Calendar Year Deductible	This deductible applies to both medical and behavioral health benefits	
Individual	None	$300
Family Limit	None	$600
Annual Out-of-Pocket Maximum	This maximum includes your deductible and co-insurance payment for medical and behavioral health benefits	
Individual	None	$6,500
Family Limit	None	$13,000
No Lifetime Maximum Benefit		
Physician Services Co-pay/Visit		
Primary Care Physician (PCP)	$15 co-pay/visit	40% of R&C after deductible plus excess over R&C
Specialist Physician	$30 co-pay/visit	40% of R&C after deductible plus excess over R&C
Short Term Rehabilitation (STR)	$10 co-pay/visit	40% of R&C after deductible plus excess over R&C
Behavioral Health Provider	$15 co-pay/visit	40% of R&C after deductible plus excess over R&C
Preventive Care Co-pay/visit	$15 co-pay/visit	**In-Network Only**
Maternity Care Co-pay (one co-pay/*pregnancy*)	$15 co-pay/pregnancy	40% of R&C after deductible plus excess over R&C
Hospital Care		
Hospital Inpatient Care including professional services **(Precertification Required)**	$0 (Paid in full by Plan)	40% of R&C after deductible plus excess over R&C
Hospital Outpatient Surgery/Testing	$0 (Paid in full by Plan)	40% of R&C after deductible plus excess over R&C
Emergency Room Co-pay **(true emergency only/waived if admitted)**	$25 co-pay/visit	Treated as In-Network
Urgent Care Center Co-pay	$25 co-pay/visit	40% of R&C after deductible plus excess over R&C
Ambulance	$0 (Paid in full by Plan)	40% of R&C after deductible plus excess over R&C
Prescription Drug		
Prescription Brand Deductible per Family	**$500 Deductible applies to all Brand Name Drugs when a generic equivalent is available**	
RETAIL		
Retail Copay - up to 30-day supply (Generic)	$5	$5
Retail Copay - up to 30-day supply (Preferred Brand)	$10	$10
Retail Copay - up to 30-day supply (Non-Preferred Brand)	$25	$25
		Plus excess over contract cost
MAIL		
Mail Order Copay - up to 90 day supply (Generic)	$5	
Mail Order Copay - up to 90 day supply (Preferred Brand)	$15	NOT COVERED
Mail Order Copay - up to 90 day supply (Non-Preferred Brand)	$50	

SUMMARY OF THE MILA NATIONAL HEALTH PLAN	
	BASIC PLAN
Features	**In-Network**
Calendar Year Deductible	This deductible applies to both medical and behavioral health benefits
Individual	$400
Family Limit	$700
Annual Out-of-Pocket Maximum	This maximum includes your deductible and co-insurance payment for medical and behavioral health benefits
Individual	$5,000
Family Limit	Not Applicable
No Lifetime Maximum Benefit	
Physician Services Co-pay/Visit	
Primary Care Physician (PCP)	$25 co-pay/visit
Specialist Physician	$40 co-pay/visit
Behavioral Health Provider	$15 co-pay/visit
Preventive Care Co-pay/visit	$25 co-pay/visit
Maternity Care Co-pay (One/*pregnancy*)	$25 co-pay/visit
Hospital Care	
Hospital Inpatient Care including professional services **(Precertification Required)**	$350 co-pay/1st Admission each year - 30% of R&C after deductible
Hospital Outpatient Surgery/Testing	30% of R&C after deductible
Emergency Room Co-pay **(True Emergency only-waived if admitted)**	$50 co-pay/visit
Urgent Care Center Co-pay	$25 co-pay/visit
Ambulance	30% of R&C after deductible
Prescription Drug	
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

SUMMARY OF THE MILA NATIONAL HEALTH PLAN	
	CORE PLAN
Features	**In-Network**
Calendar Year Deductible	This deductible applies to both medical and behavioral health benefits
Individual	$750
Family Limit	$1,500
Annual Out-of-Pocket Maximum	This maximum includes your deductible and co-insurance payment for medical and behavioral health benefits
Individual	$7,500
Family Limit	$15,000
No Lifetime Maximum Benefit	
Physician Services Co-pay/Visit	
Primary Care Physician (PCP)	$35 co-pay/visit
Specialist Physician	$50 co-pay/visit
Behavioral Health Provider	$35 co-pay/visit
Preventive Care Co-pay/visit	$35 co-pay/visit
Maternity Care Co-pay (One/*pregnancy*)	$35 co-pay/visit
Hospital Care	
Hospital Inpatient Care including professional services **(Precertification Required)**	$500 co-pay/40% of R&C after deductible
Hospital Outpatient Care including professional services	40% of R&C after deductible
Emergency Room Co-pay **(true Emergency only-waived if admitted)**	$75 co-pay/visit
Urgent Care Center Co-pay	$50 co-pay/visit
Ambulance	40% of R&C after deductible
Prescription Drug	
Prescription Brand Deductible per Individual	**$500 Deductible applies to all Brand Name Drugs**
RETAIL	
Retail Copay - 30-day supply (Generic)	$10
Retail Copay - 30-day supply (Preferred Brand)	$20
Retail Copay - 30-day supply (Non-Preferred Brand)	$50
MAIL	
Mail Order Copay - 90 day supply (Generic)	$20
Mail Order Copay - 90 day supply ((Preferred Brand)	$50
Mail Order Copay - 90 day supply ((Non-Preferred Brand)	$125

MILA/Cigna Disease Management Benefits

MILA has expanded the range of Disease Management Programs that are available to members and their families who suffer from chronic conditions by adopting Cigna's new Your Health First Program. The conditions that are treated are:

Asthma
Anxiety
Bipolar Disorder
Depression
Diabetes – Type 1
Diabetes – Type 2
Chronic Obstructive Pulmonary Disorder
Metabolic Syndrome
Angina
Congestive Heart Failure
Coronary Artery Disease
Acute Myocardial Infarction
Heart Disease
Peripheral Arterial Disease
Low Back Pain
Osteoarthritis

MILA/Cigna Behavioral Health Benefits

As you are aware, our Behavioral Health Care and our Member Assistance Programs **(MAP)** are now covered through Cigna Behavioral Health, an affiliated Cigna Health Care company. The Behavioral Health Care program is designed to help you and your family members cope with issues relating to:

Alcohol
Depression
Anxiety
Bi-Polar Disorder
Drugs/Substance Abuse
Grief & Loss
Stress
. . . and many other issues.

These support services are available to you and your family — 24 hours per day/7days per week/365 days per year. You can either access benefits by directly contacting a Cigna behavioral health care provider or you may access benefits through the MAP which provides up to 3 visits per issue free of charge. For more information on these programs, please call the phone number on the back of your MILA/Cigna I.D. card.

The program includes intervention by a dedicated health advocate who will provide the following services: (1) chronic condition specific coaching; (2) pre and post hospital discharge assistance; (3) lifestyle management coaching, including stress and weight management and tobacco cessation; and (4) treatment decision support and coaching.

MILA/Cigna Lifestyle Management Programs

These programs are available to members and their families who do not have one of the chronic diseases that are targeted by the Your Health First Program but want to address lifestyle issues. The Lifestyle Management Programs and the services they address are as follows:

Cigna Healthy Steps to Weight Loss Program	A weight management program including planning, personal coaching and educational materials.
Cigna Quit Today Program	A tobacco cessation program for anyone who wants help in stopping smoking.
Strength & Resilience Program	A stress management program which helps participants to develop work/life balance, improve their physical activity and resilience to stress and better manage their time.

Work/Life & Informational Support Program

The MILA Member Assistance Program (MAP), in addition to providing access to mental health and substance abuse services, also offers a Work/Life & Informational Support Program. The MAP program is available to our members and their eligible dependents. Get extra support for handling life's demands.

You can call the telephone number on the back of your MILA/Cigna I.D. card for advice on topics such as:

Financial Services
Child Care and Adoption Services
Pet Care
Legal Services
Elder Care, including Adult Day Care
Identity Theft
. . . and many other topics of possible concern.

A Cigna Representative is ready to help assess your needs and develop a solution to help resolve your concerns free of charge for up to 3 visits per issue, 24 hours per day/7days per week/365 days per year.

MILA/Cigna Healthy Rewards Program

Reward yourself now and access your Healthy Rewards program for **DISCOUNTS** on a wide range of health and wellness services and products such as:

Weight Management and Nutrition
Alternative Medicine
Tobacco Cessation
Fitness Club Membership
Therapeutic Massage
. . . and many other programs.

These discount programs are available to assist members who wish to supplement the many medical, disease management and lifestyle management programs that are available under the MILA program. These programs are more fully described on myCigna.com or you can call 1-800-794-7882.

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, 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.

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 Ultra 2
- 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. 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's free! Simply visit Caremark.com from your mobile Web device and register or log in to get started.

MEDICARE BENEFICIARIES – F.Y.I.

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 you or your dependents do enroll in Medicare, MILA benefits will be primary and Medicare benefits will be secondary. Any benefits payable by Medicare will be determined by Medicare after considering all benefits payable by MILA.

If you are a pensioner or the spouse or other dependent of a pensioner who is eligible 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, it 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**

Adding Newborn Children and Other Eligible Dependents

You must request that MILA add newborns that are your eligible dependent(s) to the plan. Within five months following the child's date of birth you must forward to MILA a copy of the child's birth certificate. All other dependents must be added within 30 days of the date they qualify as eligible dependents under the terms of the MILA Plan (such as marriage, adoption, legal guardianship).

To enroll dependents you are required to forward copies of the documents listed below. These documents will verify the identity of your dependent(s) and their relationship to you.

Required Documents:

For the Member's Spouse:	Marriage Certificate *(if applicable),* birth certificate, Social Security card, and Medicare card *(if applicable).*
For Dependent Children:	Birth Certificate, Social Security card, and Medicare card *(if applicable)*

Failure to provide the required documents within the time frames set forth above will result in your inability to add your dependents when they would otherwise be eligible for Plan coverage. Their coverage will be deferred until all of the required documents have been provided to MILA.

NOTICES ENCLOSED:

- **Women's Health and Cancer Rights Act of 1998**
- **MILA Privacy Notice**
- **Early Retiree Reinsurance Program (ERRP)**

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.

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 August 1, 2012.

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, or electronic 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 HHS***. 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.

Disclosure to the Plan's Trustees. The Plan will also disclose PHI to the Plan Sponsor of the MILA Managed Health Care Trust Fund for purposes related to treatment, payment, and health care operations, and the Plan has amended the Plan Documents to permit this use and disclosure as required by federal law.

When the Disclosure of Your PHI Requires Your Written Authorization

Although the Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

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.

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 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,

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

- 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 applicable 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.
4. ***Health oversight activities.*** To a 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 the Department of Labor).
5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is made pursuant to court order.
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, including:
   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
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. The Plan may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
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.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

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.

Section 3: Your Individual Privacy Rights

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 if the Plan Administrator or Privacy/Security Officer determines it to be unreasonable.

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 contained in a "designated record set," for as long as the Plan maintains the PHI.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

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 fee may be charged. Requests for access to PHI should be made to Privacy/Security Officer at the address on page 16.

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 HHS.

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 Office at the address found on page 16.

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. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. See the Plan's Accounting for Disclosure Policy for the complete list of disclosures for which an accounting is not required.

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 found on page 16.

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. 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 un-emancipated 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 un-emancipated 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.

You should also review the Plan's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Plan will automatically consider an individual to be a personal representative.

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.

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.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change 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.

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

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services ("HHS"). HHS recommends that you use the OCR Health Information Privacy Complaint Form Package. You can also request a copy of this form from an OCR regional office. If you need help filing a complaint or have a question about the complaint or consent forms, you can e-mail OCR at OCRMail@hhs.gov. Please contact the nearest office of the Department of Health and Human Services, listed in your telephone directory, visit the HHS website at http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html, or contact the Privacy Official for more information about how to file a complaint. 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 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.

NOTICE
EARLY RETIREE REINSURANCE PROGRAM

The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

The MILA Managed Healthcare Trust Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for 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 plan administrator at the MILA Managed Health Care Trust Fund, 111 Broadway Fifth Floor, Suite 502, New York, NY 10006-190; Phone: (212) 766-5700; Fax: (212) 766-0844; Fax: (212) 766-0845; E-mail: info@milamhctf.com; E-mail: milamhctf@aol.com. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.