Summary of Material Modifications

MILA Managed Health Care Trust Fund
National Health Plan

Plan Changes Adopted
During Plan Years 2008 through 2011

MILA

The MILA National Health Plan

Summaries of Material Modification 2008 through 2011

The MILA National Health Plan issued a Summary Plan Description (SPD) in booklet form in June 2008. This SPD provided a thorough description of the MILA medical, behavioral health and prescription drug coverage that is available:

- To qualified members and their eligible family members under the Premier, Basic and Core plans, and
- To qualified pensioners and their eligible family members under the Premier, Basic and Medicare Wrap-Around plans.

Since that SPD was published, the MILA Trustees have made several benefit enhancements and changes to the MILA National Health Plan. In addition, they also have directed that clarifications to the Plan be published to help members better understand important features of the Plan. Accordingly, Summaries of Material Modification (SMMs) were issued announcing enhancements and clarifications during November of each year: 2008 through 2011. This document provides a compilation of the SMM announcements in one easy-to-access document.

If you have questions concerning the information contained in this document, please call, e-mail or fax the MILA Fund Office using the contact information supplied in your SPD on page 91.

Summary Plan Description (SPD) Changes/Clarification

In using the MILA Summary Plan Description since its publication in June 2008, we have found several areas of coverage where further discussion is helpful to ensure that the benefit plan description is more accurate. Although these changes are minor, it is essential that this description of the benefit plans be provided to Plan Participants and their beneficiaries.

- **Page 15, In-Network Plan Benefits in the Basic Plan.** When you are hospitalized in an In-Network hospital, you will pay a copay of $350 and then 30% of the remaining cost. If you are hospitalized an additional time during the year, a second copay will not apply but you will pay 30% of the cost until you have paid an amount equal to your out-of-pocket maximum for that year.
- **Page 34, Understanding what is covered in "care from a Specialist."** One type of specialty care that is listed is for acupuncture or acupressure. Care is covered only if it is provided by a Network provider and the covered cost is limited to $80 per visit.
- **Page 34, Understanding what is covered in "care from a Specialist."** A specialist might provide treatment for conditions affecting the joints between the jawbone and the skull, known as temporomandibular joint (TMJ) disorder or craniomandibular joint disorder. Covered expenses are limited to non-surgical treatment and reimbursement for those expenses is limited to no more than $1,000 per calendar year. Further, there is no coverage provided for the surgical treatment of these disorders.
- **Page 35, Understanding what is covered under "Urgent Care."** If you need an ambulance for emergency care in a hospital emergency room, the Plan will pay in accordance with the benefit provisions of the Plan in which you are enrolled.
- **Page 37, Understanding what is covered under "Ambulance Service."** Costs are paid in accordance with the benefit provision of the Plan in which you are enrolled for licensed ambulance service to or from the nearest hospital, skilled nursing facility or hospice where the patient can get needed medical care or treatment.
- **Page 48, Understanding what is covered under "Medical expenses not covered under the Plan – Home Health Care."** The following additional bullet describing care which is not covered is added to the description of care not covered: "Care which is designed to provide assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest or domiciliary or convalescent care.
- **Page 48, Understanding what is covered under "Medical expenses not covered under the Plan — fertility tests or procedures to correct infertility."** The statements under this bullet should read as follows: Fertility tests and procedures performed by an Out-of-Network provider to correct infertility are not covered unless you are eligible for out-of-area benefits. However, the actual or attempted impregnation or other fertilization expenses, including but not limited to artificial insemination, in vitro fertilization, embryo transplant, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and related procedures or services are not covered under the Plan whether performed by a Network or an Out-of-Network provider.

- **Page 59, Your Orphaned Children.** Your unmarried child or children who are orphaned while they are covered under the Plan will remain eligible for coverage while they remain within the Plan's limiting age provided that they are not covered under another Plan with which MILA would otherwise coordinate its benefits and provided they do not qualify for coverage as a result of employment. MILA coordinates its benefits with other group plans, including multi-employer and association plans, whether insured or self-funded and with certain governmental plans. It does not coordinate its benefits with individual insurance plans. See page 53-54 for more information on MILA's Coordination of Benefits provisions.
- **Page 64, Participation under the Plan, in the table contained in "When Coverage Ends."** Coverage will end for the Surviving Spouse and for any eligible dependent children on the date the Surviving Spouse remarries.
- **Page 64, Participation under the Plan, in the table contained in "When Coverage Ends."** Coverage for the incapacitated child will end on the date he or she is no longer incapacitated or the date on which he or she is no longer dependent upon you or your Surviving Spouse for support and maintenance. However, if your incapacitated child is orphaned, coverage for that incapacitated child will continue as long as he or she remains incapacitated and is not a ward of the Court or any government.
- **Page 74, Medicare Advantage Plans.** If a MILA pensioner or that pensioner's spouse or dependents elects coverage under a Medicare Advantage Plan, that individual will have coverage under the Medicare Advantage Plan instead of coverage under MILA. If a medical service or supply is not covered under that Plan, it will not be eligible for coverage under MILA. Therefore, it is extremely important for a person who elects coverage under a Medicare Advantage Plan to maintain full Medicare coverage (that is, coverage under Medicare Parts A, B and D).

Important Reminders

Medicare's Prescription Drug Program

If you are a pensioner who is covered in the MILA Medicare Wraparound Plan and you enroll in a Medicare Part D Medicare Prescription Drug Plan, your MILA prescription coverage with CVS Caremark will be terminated for both you and your dependents. If your spouse is eligible for Medicare and enrolls in Medicare Part D, MILA's prescription coverage will be terminated only for your spouse. For most members MILA's prescription coverage through CVS Caremark provides prescription coverage that is at least as good as and frequently much better than coverage provided through a Medicare Part D Prescription Drug Plan. If you are considering enrolling in a Medicare Part D Prescription Drug Plan, you should carefully review the MILA Summary Plan Description on pages 22 and 23.

Coverage for surviving spouses and children of an active longshore employee or a pensioner with 25 years or more years of service:

If an active longshore employee or a pensioner dies on or after May 1, 2008, and that active employee or pensioner had 25 or more years of credited service, the surviving spouses and any eligible dependents will qualify for MILA health care benefits.

Notifications to MILA – Loss of Coverage by Spouse or Dependent Child.

Under the COBRA Continuation of Coverage law, you or your dependent are responsible for notifying MILA of the occurrence of certain qualifying events under which you or your dependent will lose coverage under the Plan. Those qualifying events are your divorce or your child ceasing to be an eligible dependent under the Plan. If you fail to notify MILA within 60 days of the date your coverage terminates due to the occurrence of one of these events, you will lose the right to continue coverage. In addition, if any claims are paid by the Plan after coverage should have been terminated, you will be responsible for reimbursing the Plan for the cost of those claims.

Notifications to MILA — Eligible to enroll in Medicare

The Plan requires that if you are a pensioner or the dependent of a pensioner and you become eligible to enroll in Medicare, you must enroll and you must notify the Plan immediately in order that we may pay claims correctly. In addition, if you return to active work after you have enrolled in Medicare as a pensioner or the dependent of a pensioner, the Plan requires that you notify MILA immediately in order that we may pay claims correctly.

If you have MILA coverage because of credited hours and you have not retired, you do not need to enroll in Medicare. If you elect to enroll in Medicare, MILA will be your primary coverage and Medicare will be your secondary coverage.

Notifications to MILA — Dependent Enrollment Requirement

You must enroll your eligible dependents in order for them to have coverage under MILA. If you enroll an eligible dependent within 31 days of that person becoming eligible for coverage, then coverage will begin on that date the person was eligible. If you enroll the person after 31 days from the date the person was eligible, then coverage will not begin until the person is enrolled. For example, if you were married on June 15, you would have until July 16 to enroll your spouse and coverage would begin on the date of your marriage. Otherwise, your spouse's coverage would not begin until you enrolled him or her.

Effective October 2008 — Enhancements to the Prescription Program

Automatic Prescription Refill and Renewal Program

This voluntary program combines the benefits of mail service with the convenience of automatic prescription refills and/or renewals. If you or a family member takes maintenance medications for a chronic condition or long-term therapy, you may elect to participate in the CVS Caremark Mail Service Pharmacy's new automatic prescription refill and/or automatic prescription renewal program for those prescription drugs. This new program would then provide you with the convenience and ease of automatic refills and renewals.

To find out if your maintenance medications are eligible and to take advantage of this service at no additional cost to you, simply log on to **www.caremark.com** and click on "Refill Prescriptions" or call Customer Care at the toll-free number on the back of your prescription benefit ID card.

Here's How the Program Works

Automatic refills and/or automatic renewals are available for most common maintenance medications for chronic conditions or for long-term therapy. A few examples of drugs that are particularly suitable for this program include medications for managing high blood pressure, high cholesterol and diabetes.

1. **Automatic Prescription Refill**
   Several days before it is time for your mail service prescription to be refilled, CVS Caremark will send you an alert that your order automatically will be refilled unless you tell CVS Caremark not to fill your prescription. If CVS Caremark does not hear from you before the normal refill date, the prescription will be filled and automatically sent to you at the appropriate time. If you need to cancel the order, you can do so. This helps ensure that CVS Caremark will only send you a refill for a medication that you are still taking.
2. **Automatic Prescription Renewal**
   CVS Caremark will request a new prescription from your doctor when your prescription is about to expire or when the last refill has been used. Before a prescription expires or runs out of refills, CVS Caremark will send you an alert that it is contacting your doctor to obtain a new prescription. If you need to cancel the order, you can do so.

3. **Enrollment**
   You can conveniently enroll by visiting **www.caremark.com** and clicking on "Refill Prescriptions" or by calling Customer Care at the toll-free number on the back of your ID card. If you enroll on **www.caremark.com**, all prescriptions eligible for the program will have a check box. If you enroll by calling Customer Care, the representative will tell you which prescriptions are eligible. You will choose which prescriptions will be in the automatic refill or automatic renewal program.

In addition to telling us which prescriptions to include, you will need to tell us how you would like to be contacted (automated phone call, e-mail or text message) for receiving messages regarding mail service prescription orders. You also will be asked to provide your credit/debit card payment information at the time you enroll in the automatic refill and/or renewal program. Your credit/debit card will be charged when prescription orders are shipped. **Once your order has shipped, prescriptions cannot be returned for credit.**

Benefits for You

The automatic prescription refill and/or renewal program:

- Makes managing your medications easier.
- Gives you greater convenience.
- Helps ensure that you take your medicine regularly, as instructed by your doctor. Doing so will help you to stay healthier and avoid costly emergency room visits and hospital stays.
- Helps you save money by eliminating unnecessary doctor visits. If your medical condition is well managed, you may not need to visit the doctor just to receive a new prescription. The automatic renewal program takes care of getting the new prescription for you.

For more information or to enroll in the program, please call Customer Care at the toll-free number on the back of your benefit ID card or visit the website at **www.caremark.com** and click on "Refill Prescriptions."

Effective December 2008

MILA/CVS Caremark ExtraCare Health Card

To increase MILA participants' satisfaction, we are pleased to offer to all MILA participants, the ExtraCare Health Card Program. As a MILA participant, you can now receive a 20% discount off the purchase price of CVS store brand health-related products. Discounts are automatic at the register when you or a family member uses the card. The 20% discount is restricted and only applies to store brand products classified by CVS Caremark as health related. It does not apply to the purchase of alcohol, gift cards, lottery tickets, money orders, prescriptions, postage stamps, pre-paid cards, tobacco products, photo finishing or purchases made at **www.cvs.com.**

Effective January 1, 2009

MILA/CVS Caremark Maintenance Choice Program

We are pleased to tell you about an important change to your prescription benefit plan. Starting **January 1, 2009,** you will have a *choice* of receiving your long-term medications (maintenance drugs), up to a 90-day supply, at either a **CVS Caremark Pharmacy** retail store or through **CVS Caremark Mail Service Pharmacy.**

Your prescription benefit plan will allow only two 30-day fills (a new prescription and one refill) at a network retail pharmacy. After these two fills, the Plan will only cover 90-day fill prescriptions and these prescriptions must be filled through the **CVS Caremark Mail Service Pharmacy.** Beginning on January 1, 2009, you may have these 90-day supply prescriptions filled either by a local **CVS Caremark**

Pharmacy or by the **CVS Caremark Mail Service Pharmacy.** You will pay the same lower mail-service copay at either location.

Choose what is more convenient for you. The copay is the same either way.

- If you currently receive your long-term medications from CVS Caremark Mail Service and wish to continue — **no action is required.**
- If you want to change how you receive your long-term medications by switching from the **CVS Caremark Mail Service** to a **CVS Caremark Pharmacy,** call CVS Caremark Customer Care toll free at 1**-866-875-MILA (1-866-875-6452)** and *we'll take care of it for you.* We will contact you after your last allowable fill at CVS Caremark Mail Service and, with your permission, we will contact your doctor to get a 90-day prescription to have filled based on your choice of pharmacy (Mail or Retail).
- If you have questions, please call CVS Caremark Customer Care toll-free at **1-866-875-MILA (1-866-875-6452).** CVS Caremark Customer Care is open 24 hours a day, seven days a week. Alternatively, you can visit **www.caremark.com.**

What's New

Regional Distribution for Mail Order Prescriptions

MILA and CVS Caremark are committed to continuous process and system improvements that will help increase operational efficiency and improve the service to our plan participants.

Beginning during 2009, one of MILA's new enhancements is regional distribution. Regional distribution uses our mail facility locations to ship medications to participants from a location that will provide a shorter delivery time.

The key benefit to our participants is increased satisfaction due to faster turnaround time. Many members can expect orders with shorter delivery times since the orders are now being dispensed from a pharmacy that is closer to their home. You may notice that your prescriptions are being shipped from a different pharmacy, but aside from the postmark, there should be no difference in the physical appearance of the order.

Frequently Asked Questions

Q1: Why is my prescription coming from a different location than where I received it previously?

A1: ***Regional distribution allows for shipping your prescription from the closest pharmacy to where you live, helping to decrease the amount of time it takes you to receive your medication.***

Q2: Will my prescription always come from the closest pharmacy?

A2: ***In most cases, yes. However, on occasion we may not ship from the location geographically closest to you because of postal delivery logistics, client mandate or regulatory issues.***

Q3: Why was I not notified that I would possibly be receiving my prescription from a different location?

A3: ***Your prescriptions are routed behind the scenes to the appropriate dispensing pharmacy. The regional distribution enhancement is practically invisible to you since all our pharmacies use consistent processes and packaging. The only visible difference is the return address on the package.***

MILA Disease Management Programs

The MILA/CIGNA Well Aware for Better Health Disease Management Programs are available to assist participants who are living with the following chronic health conditions:

- Heart Disease;
- Diabetes;
- Low Back Pain;
- Asthma;* and
- Weight Complications.*

** The programs designated by an asterisk have been available since 1/1/2009.*

CIGNA Lifestyle Management Program (Healthy Steps to Weight Loss)

This program helps the participant who elects the program to manage his or her weight by using an individually appropriate combination of diet and non-diet approaches with the help of your personal physician and a dedicated Wellness Coach. It assists the individual by building confidence, becoming more active, eating healthier and changing habits that will help him or her feel better, look better and improve their overall health.

For more information on either the Disease Management Programs or on the Lifestyle Management Program (Healthy Steps to Weight Loss), contact MILA. You may also contact our Well Aware Team for the MILA/CIGNA Well Aware for Better Health Disease Management Programs at **1-866-797-5833** or visit the CIGNA Health Care website at **www.cigna.com/betterhealth** or call the number on the back of your MILA/CIGNA I.D. card.

CIGNA Healthy Pregnancies, Healthy Babies Program

The CIGNA Healthy Pregnancies, Healthy Babies program aims to identify participants with risk factors so they can begin a plan of care early on in their pregnancies that could help minimize potential complications or premature births. To enroll, just call the toll-free number on your MILA/CIGNA I.D. card any time during your pregnancy.

Walk-in Clinics

- Walk-in Clinics are located in or near convenient retail stores and pharmacies such as: Target, CVS Caremark Pharmacies, and in-store health clinics, such as Minute Clinics in CVS Caremark Pharmacies, Little Clinic in Kroger and Publix stores and TakeCare Health Clinics in Walgreens and Eckerd stores.

- Care is provided quickly and conveniently, and with personal attention, from certified nurse practitioners and physician assistants qualified to evaluate, diagnose and prescribe medications for common illnesses such as strep throat, or pink eye. Care rendered at one of the designated walk-in clinics is in-network and is subject to a primary care copay.

During 2011 Various Benefits were Added or Revised and Improved

The details of those additions and improvements were distributed during December 2010 to all MILA Members and their dependents in a letter that was sent together with Benefit Brochures entitled as follows:

MILA — Your Wellness Plan

This brochure announced that on January 1, 2011, CIGNA Behavioral Health would begin providing the services under MILA's Member Assistance Program (MAP) and it also would begin providing the Behavioral Health Network and the claim administration services that provide for the delivery of MILA's Behavioral Health Plan benefits. Not only would this change permit MILA to more closely integrate behavioral health with other medical care and to provide truly "open access" to behavioral health professional services; it also permitted MILA to provide the additional service integration between the medical and behavioral health benefits required by the federal law entitled, "Mental Health Parity and Addiction Equity Act of 2008."

MILA's Behavioral Health Care and Member Assistance Programs (MAP) have been designed to help you and your family members cope with issues relating to:

- Alcohol;
- Depression;
- Grief & Loss;
- Drugs/Substance Abuse;
- Stress; and
- Much more.

These support services are available to you and your family through the MAP — free of charge, 24 hours/7 days per week/365 days per year through CIGNA Health Care for up to three visits. Thereafter, your visits and treatment will be covered under the provisions of MILA's Behavior Health Program provided through CIGNA Behavioral Health.

For more information on these programs, please call the phone number on the back of your I.D. card.

Work/Life & Informational Support Program

The MILA MAP Program, in addition to providing mental health and substance abuse services, also offers a Work/Life & Informational Support Program. This 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; and
- Identity Theft.

A CIGNA Representative is ready to help assess your needs and develop a solution to help resolve your concerns 24 hours/7 days per week/365 days per year.

MILA/CIGNA Healthy Rewards Program

Reward yourself now and access your **Health 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
- Much more.

MILA — Your Dental Plan

This brochure provided a detailed description of the new MILA dental plan benefits that were effective January 1, 2011, and that replaced local dental plans which may have previously been administered by each Port. Aetna provides the network of dentists from whom members can receive the highest level of benefits under the Plan.

If a member chooses to seek service from a dentist who does not participate in the Aetna network, that dentist will be paid the same amount as would a participating dentist. However, that dentist might charge the member more than the participating Aetna Network dentist has agreed to charge in MILA's negotiated arrangement. Aetna is also MILA's Claims Administrator for all dental claims.

MILA — Your Vision Plan

This brochure provided a detailed description of the new MILA vision plan benefits that were effective January 1, 2011, and that replaced local vision plans which may have previously been administered by each Port. EyeMed Vision Care provides the network of commercial optical stores and the optical professionals from whom members can receive the highest level of benefits under the Plan.

If a member chooses to seek vision services from an optical professional or store that does not participate in the EyeMed network, that professional or store will be paid the same amount as would a participating professional or store. However, the payment might not cover the full charge the member must pay the non-participating professional or store. EyeMed professionals and stores have agreed to accept charges that have been negotiated for the MILA Plan. EyeMed is also MILA's Claims Administrator for all vision care claims.

What's New Under CVS Caremark in 2011

The CVS Caremark Pharmacy Advisory Program

This program was introduced in the MILA Pharmacy Program on March 1, 2011, by CVS Caremark. Caremark provides special advisory services to participants who have diabetes when they present their prescriptions for filling or refilling at a CVS Caremark Pharmacy or to MILA's mail order CVS Caremark Pharmacy.

Participants who have diabetes frequently take more than one drug and can benefit from additional information about the importance of taking their prescribed medication and the best way to manage taking several drugs. The program is designed to supplement the information that has been supplied by the person's physician in order that the individual may follow his or her physician's instructions more fully.

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; and
- 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; and
- LifeScan OneTouch UltraMini.

If you are eligible under the MILA Plan, you may qualify for an ACCU-CHEK or LifeScan OneTouch blood glucose meter at **no cost to you** when you order a 90-day supply of ACCU-CHEK or LifeScan OneTouch glucose meter test strips from our mail service pharmacy.

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/CIGNA I.D. card.

Mobile Website — www.caremark.com

You can now manage your prescription needs from your cell phone or your iPhone. 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 **www.caremark.com** from your mobile Web device and register or log in to get started.

Health Care Reform Status for MILA, Effective January 1, 2011

Coverage for Children up to Age 26

Beginning on January 1, 2011, your child (or children) who previously lost the right to MILA coverage may again be eligible, provided the child's parent continues to be eligible for MILA benefits. This change has occurred because MILA will comply with 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) that was recently signed into law by President Barack Obama.

This law required the Plan to change and expand the definition of who qualifies as a dependent child on January 1, 2011, 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
- The Plan will provide that coverage will terminate on the date that the child is employed and has the right to elect that employer's medical coverage (regardless of whether the employer's plan is as good as the MILA plan).

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 National Medical Support Notice (NMSN). The Trustees have agreed that children will remain eligible until the end of the month in which they attain age 26 unless they first become eligible to elect medical coverage through their employer as indicated above.

Please note that a member's children will remain eligible until the attainment of age 26 as long as the member continues to be eligible for MILA benefits.

Grandfathered Status: MILA is a "Grandfathered" Plan under the Patient Protection and Affordable Care Act (PPACA or Health Reform)

A great deal has been written since the passage of health care reform earlier this year. One of the major issues has been whether or not a particular plan is "grandfathered." A grandfathered plan is exempt from the provisions of the PPACA requiring coverage for recommended preventive care, coverage for emergency room services, choosing a primary care provider, enhanced appeals procedures for disallowed claims and nondiscrimination rules based on income levels.

A grandfathered plan must comply with the PPACA provisions requiring coverage of children up to age 26, annual and lifetime limit restrictions, and prohibitions on pre-existing conditions for persons up to age 19. The chief benefit of remaining as a grandfathered plan is that the plan can remain as is, with the exception of having to make the changes noted above.

The MILA Premier, Basic and Core Plans are grandfathered plans. The MILA Wrap-Around Plan is not subject to any of the requirements of PPACA. Aside from making the changes required by PPACA noted above, it is expected that the current MILA Plan provisions will remain unchanged through at least September 30, 2012, when the USMX-ILA Master Contract expires.

Although the MILA plans are grandfathered plans that are not required to make certain changes required by PPACA as noted above, the MILA benefit plans already include nearly every one of the benefit provisions which PPACA is imposing on plans that are not grandfathered. Furthermore, in order to retain the status as grandfathered plans, MILA cannot eliminate benefits, adopt or decrease annual benefit limits, increase co-insurance, increase deductibles or out-of-pocket maximums or increase copays.

However, always remember that the MILA Board of Trustees reserves the right, in its sole and absolute discretion, to amend or end this Plan at any time, subject to the terms of the applicable collective bargaining agreements. Finally, the parties to the Master Contract reserve the right to amend or end this Plan at any time.

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 MILA at the address and/or telephone number provided in the Summary Plan Description. 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.

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.

December 2011, 10,000