HEALTH,

WELFARE,

AND CLINIC FUND

SUMMARY PLAN DESCRIPTION

January 1, 2015

Redrafted 4/27/15

This document has been designed to inform you of the benefits that are available under the Plan, how you become eligible and when, what benefits you and your family are entitled to, and many other facts you will need to know. It is intended to meet the requirements for a Plan Description and Summary Plan Description under the Employee Retirement Income Security Act ("ERISA"). Your Plan benefits are an important segment of your total compensation package. Please read this information carefully.

THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THE PLAN OR PLAN POLICIES WHENEVER, IN THEIR JUDGMENT, CONDITIONS SO WARRANT. No benefits or rules described in this Plan Description are guaranteed (vested) for any participant, retiree, spouse or dependent. All benefits and rules may be changed, reduced or eliminated at any time by the Board of Trustees, at its discretion. This document describes the provisions of the Plan and incorporates by reference the insurance policies in effect on the date this document was issued. The insurance policies take precedence over this document; to the extent, if any, that the terms of the policies differ from the terms of this Plan document, the terms of the policies prevail. This Plan description is not meant to interpret, extend or change any of the provisions of those policies.

Only the Trustees have the authority to make decisions for the Fund. No Local Union Officer, Business Agent, Local Union Employee, Employer or Employer Representative, Fund Office personnel, consultant, attorney or any other person is authorized to speak for, or on behalf of, or to commit the Trustees of this Fund on any matter relating to that Fund without the express authority of the Trustees.

Only the Trustees of the Fund have the authority to determine, among other things, eligibility for benefits and the right to participate in the Fund, including the manner in which hours are credited, eligibility for any benefit, discontinuance of benefits, status as a covered or non-covered employee, the level of benefits, and the interpretation and application of rules and regulations to a particular claim or application.

The Trustees may enter into insurance agreements with insurance carriers to provide benefits or self-insure the benefits. At this time, the Trustees have entered into agreements with Met Life and Aetna to provide you with insured weekly accident and sickness and life insurance benefits. The Trustees also provide a self-insured supplemental dental and vision benefit, which over and above the dental and vision benefits coverage you are eligible to receive through MILA. The Trustees cannot take responsibility for the quality of care or treatment decisions received from the dental or vision providers that you choose through your MILA coverage, nor will the Trustees interfere in the professional relationship between you and your provider.

The contents of this Plan Description contain only a summary of the benefits available to you under the group policies. For full and complete provisions and conditions of your weekly accident and sickness benefits, refer to the insurance certificates and materials mailed to you.

PLAN NUMBER 501
EMPLOYER IDENTIFICATION NO. 04-6063728
TYPE OF PLAN: WELFARE PLAN

The Health, Welfare, and Clinic Fund is intended to provide life insurance, accident and sickness insurance, certain spousal and retiree death benefits, and limited supplemental dental and vision benefits to Qualified Employees and their eligible Qualified Dependents. The Fund is maintained pursuant to the terms of the Collective Bargaining Agreement between the Boston Shipping Association, Inc. and the International Longshoremen's Association AFL-CIO. A copy of this Agreement may be obtained by participants and their spouses or other beneficiaries upon written request to the Plan Administrator and is available for examination by participants and their spouses.

A complete list of the employers and employee organizations sponsoring the Plan may be obtained by participants and their spouses or other beneficiaries upon written request to the Plan Administrator and is available for examination by participants and their spouses. Participants and their spouses or other beneficiaries may also receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a Plan sponsor, and if the employer is a Plan sponsor, the sponsor's address.

Participating Employers contribute to the Trust Fund in accordance with the Collective Bargaining Agreement. The Trust Fund's Board of Trustees reserves the right to amend, modify, discontinue or terminate all or part of this plan of benefits whenever, in its judgment, conditions so warrant.

TABLE OF CONTENTS

Definitions

In this Plan, masculine gender shall include the feminine, and the singular shall include the plural, unless the context otherwise requires, and the following words shall have the following meanings.

Employee – means (a) each individual who now or hereafter is employed as a Longshoreman, Clerk or Line Handler by an Employer and for whom an Employer makes contributions to the Fund, and (b) a Union Representative.

Employer – means an employer-member of the Boston Shipping Association ("BSA") obligated under the terms of a collective bargaining agreement with the Union, as well as the Board of Trustees or the Union where applicable.

Hour of Service – see Eligibility and Coverage section.

Participating Employer – means an Employer obligated to contribute to the BSA-ILA Health, Welfare and Clinic Fund under the terms of a collective bargaining agreement.

Plan Administrator – means the Fund's Board of Trustees, who can be contacted via the BSA-ILA Health Welfare & Clinic Fund office, Charlestown Navy Yard, 197 8th Street, Suite 775 Charlestown, MA 02129 ((617) 242-3303).

Qualified Employee – means an Employee who has been credited with at least 700 Hours of Service in the preceding contract year (October 1 to September 30), or an Employee credited with between 650 and 700 Hours of Service for an Employer during the preceding contract year (October 1 to September 30), whose case was reviewed by the Trustees and deemed qualified by the Trustees as more fully set forth below, or an employee entitled to benefits under USERRA.

Qualified Dependent – includes the lawfully married spouse of a Qualified Employee and unmarried dependent children, whether natural-born, adopted, stepchildren through a legal marriage or other children under your legal guardianship who are primarily dependent on you for support and maintenance, up to age twenty-one or up to the age that those dependent children are eligible for coverage under the provisions of the insurance carriers under agreement with the Plan, if proof of marital or dependent status is produced in the form of a marriage or birth certificate, tax return, and/or a Qualified Medical Child Support Order. If your child is a full-time student at an accredited institute of higher learning, eligibility continues to age twenty-three while the child continues to be dependent and registered as a full-time student, or as long as required under the provisions of the insurance carriers under agreement with the plan and applicable law.

Trust Fund, Fund or Plan – means the BSA-ILA Health, Welfare and Clinic Plan, which was established pursuant to the collective bargaining agreement ("Bargaining Agreement") between employer members of the BSA and the International Longshoremen's Association ("ILA") for the Port of Boston, and for the benefit of employees working under that bargaining agreement.

Union Representative – means a member of the ILA who at some time has performed an Hour of Service for an Employer, serving as Delegate, Business Agent, and Representative or as an employee of a union fringe benefit fund.

ELIGIBILITY AND COVERAGE

Your eligibility for the Plan commences when you are employed by a Participating Employer as a Longshoreman, Clerk, or Line Handler, and the Employer makes contributions to the Plan on your behalf. Union Representatives, which include union fringe benefit fund employees, are also eligible for the Plan.

To qualify for coverage under the Plan each calendar year, you must be credited with at least 700 Hours of Service in the preceding contract year (October 1 to September 30). For example if you work 700 or more hours in the October 1, 2000 through September 30, 2001, contract year, you would qualify for coverage for the entire calendar year of 2002, commencing January 1.

An Hour of Service is each hour that you are directly or indirectly paid or entitled to payment by a Participating Employer for:

- The performance of duties as a Longshoreman, Clerk, Line Handler or Union Representative.
- Hours credited during periods of absence arising from work related injuries for which the participant is entitled to benefits from worker's compensation or benefits under any other applicable law.

If you fail to meet the hours requirement above, you may still qualify for coverage under one of the following rules:

- If you were credited with between 650 and 700 Hours of Service during the preceding contract year and you are deemed qualified or eligible for coverage by the Trustees.
- Short-Term Disability - If you work less than 700 hours because of illness or injury, your coverage will be continued for one additional calendar year if you qualified for coverage in the preceding two years, and provide medical evidence satisfactory to the Trustees in their sole and exclusive discretion. If you qualified for coverage during the preceding contract year and are absent because of an on or off the job injury or illness, you will receive a pro-rata credit up to a maximum of 700 hours in the Plan year in which the illness or injury occurred.
- Long-Term Disability - If your disability continues into another contract year (beyond that described above in Short-Term Disability) and you have not yet retired, your coverage will be continued for one additional year for each 5 continuous years you

qualified for coverage prior to your disability. You must provide medical evidence satisfactory to the Trustees in their sole and exclusive discretion of your continued disability.

- Retirement - If you retire under the BSA-ILA Pension Plan, your coverage will continue for the remainder of the calendar year in which you retired. If you were credited with at least 700 hours in the contract year in which you retired, your coverage will continue for the next following calendar year as well.

Termination of Coverage

Your coverage as a Qualified Employee under the Plan will end when you no longer qualify under the rules above. However, if you are eligible for a retirement benefit under the BSA-ILA Pension Plan, you may be eligible for the Retiree Benefits described in this booklet under each benefit section. In addition, you may elect to continue Life Insurance coverage at your own expense, as described below in the Life Insurance section of this booklet.

LIFE INSURANCE

Each Qualified Employee is insured by group life insurance in an amount currently set by the Trustees at $50,000. If the Qualified Employee completes the appropriate election form as provided by the Plan Administrator for this benefit, the amount currently set for the benefit is $100,000. The Trustees have the right to change these amounts or terminate this benefit at any time. Life Insurance benefits are insured and paid by the Aetna Insurance Company.

The full amount of your Life Insurance is payable to your designated beneficiary in the event of your death while your Plan coverage is in effect.

When you enroll in the Plan, you may name one or more persons as your beneficiary, and you may specify the percentage of benefits payable to each (otherwise, benefits will be shared equally). You can change your beneficiary designation at any time, by completing the appropriate form, which is available from the Plan Administrator, and submitting it to the Plan Administrator.

If you have no surviving beneficiary at the time of your death, Plan benefits become payable to your estate.

Benefits are normally paid in a lump sum. However, other payment methods such as installment payments are available from the insurance company. You may elect any available payment option by communicating your choice to the insurance company or you can leave the choice to be made by your beneficiary after your death. For more information about the election of payment options, contact the Plan Administrator.

If you retire at age 62 and up to age 65, your life insurance coverage will continue through the calendar year in which you turn age 65. If you retire at age 65 and work one hour in the year in which

you retire you will receive life insurance coverage through the end of the following calendar year. If you retire under a disability retirement, you will receive life insurance coverage for the two years following the contract year in which you retired, or longer, as described below under Extended Coverage During Disability.

How to File a Claim

In the event of the death of an insured individual, the designated beneficiary must contact the Plan Administrator, who will provide the beneficiary with the necessary instructions and assistance in filing a claim for Plan benefits.

Extended Coverage during Disability

If you become totally disabled while you are insured and before you reach age 60, your Life Insurance coverage may continue at no cost to you as long you cannot perform any work for pay or profit. The disability must result from an injury or sickness.

Life Insurance coverage will continue for one or more years after total disability begins. During the first year, if total disability lasts for 9 months with no interruption, you must submit proof of the continuing disability to the insurance carrier. You must do so within 3 months before that year ends. If you meet these requirements, your life insurance will continue for a second one-year period. If you meet these requirements in each subsequent year, your insurance will continue for each subsequent one-year period.

While insurance is continued, the insurance carrier may choose a physician to examine you as often as needed to verify your disability. These examinations will be paid for by the carrier.

Continuation of life insurance will end on the date:

- ☐ Total disability ends;
- ☐ Proof of total disability is not given by you when due; or
- ☐ You are not examined when required.

When continuation of life insurance coverage ends, you may convert your coverage to an individual policy, as described below.

Conversion Privileges

Within 31 days after your Life Insurance coverage terminates for any reason, you may convert your coverage to an individual insurance policy without taking a medical examination. The cost for coverage will be based on the insurance company's regular premium rates for your age, and the type and amount of insurance available to you when your coverage terminates. You must apply in writing

to the insurance company and pay the first premium within 31 days after the date your Plan coverage ends.

If a covered individual dies during the 31-day conversion period, Plan benefits will be payable as before coverage terminated.

Forms and instructions for obtaining an individual policy may be obtained from the Plan Administrator.

ACCIDENT AND SICKNESS INSURANCE

If while covered as a Qualified Employee under the Plan, you become totally disabled due to a non-job related injury or sickness, you may receive a weekly payment of $500.00. Accident and Sickness insurance benefits are insured, administered and paid by the MetLife Insurance Company.

Payments will begin on the first day of an injury, or on the eighth day following your sickness, and are payable, on a two-week basis, for up to 26 weeks for each period of disability.

A non-job related injury or sickness means a condition for which a person is not entitled to benefits from worker's compensation or under a similar law, and includes sickness, pregnancy and related conditions.

No weekly benefits will be paid unless you are under the care of a doctor and are not performing any work for pay. Payments will continue as long as you are disabled, up to the maximum of 26 weeks for each period of disability. The Trustees and/or their designee may require you to undergo an independent medical examination as a condition of initial or continued eligibility.

Successive periods of disability will be considered one period of disability unless they are separated by a return to full-time work for at least two weeks.

How to File a Claim

In the event of your disability due to injury or sickness, you must contact the Plan Administrator, who will provide you with the necessary instructions and assistance in filing a claim for Plan benefits.

The full description of benefits and procedures for filing a claim are described in written materials drafted by Aetna, and incorporated by reference within this Plan Description. You will receive these written materials when you become eligible for the benefit.

If your claim for benefits is denied, please see the section below entitled "Claim and Claim Denial Review Procedure" for your rights for review of your denied claim, as well as the claims and appeals section of the materials drafted by Aetna.

SPOUSE DEATH BENEFIT

If your spouse should die while you are covered as a Qualified Employee under the Plan, you will be entitled to receive a death benefit of up to $9,000 toward burial expenses. The Trustees have the right to change this amount or terminate this benefit at any time. Payment will be made directly to the funeral director or to the individual who paid the burial expenses upon the presentation of a satisfactory proof of payment but in no event for an amount greater than $9,000.

To receive this benefit, you must submit proof of your spouse's death in the form of a certified copy of the death certificate to the Plan Administrator.

This benefit is self-insured and paid out of the assets of the Trust Fund maintained on behalf of the Plan.

SUPPLEMENTAL DENTAL BENEFITS

MILA provides Qualified Employees with dental benefits in accordance with the MILA plan for such benefits. In addition, this Fund will provide Qualified Employees with the following supplemental dental benefits:

- Coverage of the annual deductible under the MILA dental plan
- Coverage of fluoride treatments twice per year for dependent children
- Coverage of composite fillings on posterior teeth
- Coverage of temporary fillings on the same tooth without limit
- Coverage of dental implants as a major service, which is at the 85% level

Death or Retirement under the BSA-ILA Pension Plan

Death - If a Qualified Employee dies, dental insurance coverage for the employee's Qualified Dependents will be continued for the remainder of the calendar year in which the death occurs. If the Qualified Employee dies after retiring under the BSA-ILA Pension Plan, and was credited with at least 700 hours in the contract year (October to September) in which the retirement occurred, coverage will continue for those Qualified Dependents for the following calendar year as well.

Retirement - If the Qualified Employee retires under the BSA-ILA Pension Plan, dental coverage will continue for the remainder of the calendar year in which the retirement occurs. If the Qualified Employee retires under the BSA-ILA Pension Plan and is credited with at least 700 hours in the contract year (October to September) in which the retirement occurs, coverage will continue for the following calendar year as well.

SUPPLEMENTAL VISION BENEFITS

MILA provides Qualified Employees with vision benefits in accordance with the MILA plans for such benefits. In addition, this Fund will also provide Qualified Employees with the following supplemental vision benefits:

- Coverage of the $15.00 MILA copayment for eyeglass frames
- Coverage of one set of eyeglass frames every 12 months

Death or Retirement under the BSA-ILA Pension Plan

Death - If a Qualified Employee dies, vision insurance coverage for the employee's Qualified Dependents will be continued for the remainder of the calendar year in which the death occurs. If the Qualified Employee dies after retiring under the BSA-ILA Pension Plan, and was credited with at least 700 hours in the contract year (October to September) in which the retirement occurred, coverage will continue for those Qualified Dependents for the following calendar year as well.

Retirement - If the Qualified Employee retires under the BSA-ILA Pension Plan, vision coverage will continue for the remainder of the calendar year in which the retirement occurs. If the Qualified Employee retires under the BSA-ILA Pension Plan and is credited with at least 700 hours in the contract year (October to September) in which the retirement occurs, coverage will continue for the following calendar year as well.

RETIREE DEATH BENEFIT

Eligibility for the benefit described in this section begins on the date you are no longer a Qualified Employee as described in the previous sections, and you have retired under the BSA-ILA Pension Plan.

If you are a retired former Qualified Employee who dies while covered under this section, the Plan currently will pay up to $9,000 toward burial expenses. The Trustees have the right to change this amount or terminate this benefit at any time. Payment will be made directly to the funeral director or to the individual who paid the burial expenses upon the presentation of a satisfactory proof of payment but in no event for an amount greater than $9,000.

If a retired Qualified Employee's spouse dies, the Plan currently will pay up to $9,000 toward burial expenses for the spouse. If a retired former Qualified Employee dies, however, and his/her spouse is receiving a survivor's benefit and then dies, no death benefit will be paid.

Application for this benefit must be made to the Plan Administrator by submitting an invoice for the expenses and a certified copy of the death certificate.

This benefit is self-insured and paid out of the assets of the Trust Fund maintained on behalf of the Plan.

CLAIM AND CLAIM DENIAL REVIEW PROCEDURE

Claim Procedure

The individual benefit descriptions in this booklet include instructions for filing claims to receive benefits. In general, you (or your designated beneficiary, when applicable) must file a written claim on the appropriate form. You can obtain the necessary claim forms and assistance in completing these forms from the Plan Administrator or appropriate insurer. An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf as an authorized representative. The Plan may request additional information to verify that the individual is authorized to act on your behalf.

Because the accident and sickness benefits are insured by MetLife, you should review its respective claims procedures as contained in the applicable summary of benefits and subscriber certificate. Those procedures govern. If you have any questions about these procedures, or need copies of them, please contact the Plan Administrator. Generally, claims for dental and vision benefits are submitted for payment after services and treatment has been obtained, and are called "post-service claims". Under federal law, you should receive written notice on the status of your claim within 30 days of the time it was filed. If a longer time is needed, a 15-day extension may be allowed, provided you are notified of the reason for the delay before the original 30-day period expires. For disability claims, the insurer will make a decision on the claim and notify you of the decision within 45 days. If the insurer requires an extension of time due to matters beyond its control, it will notify you of the reason for the delay and when the decision will be made before the expiration of the 45-day period.

The insurer's or Plan's notice of decision should contain the following information:

1. The specific reason(s) for the adverse determination
2. Reference to the specific plan provision(s) on which the determination is based
3. A description of any additional information or material necessary to perfect the claim and an explanation of why the information or material is necessary
4. A description of the appeal procedures and applicable time limits, including a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review
5. If an internal rule, guideline or protocol was relied upon by the insurer, you will receive either a copy of the rule or a statement that such rule was relied upon in deciding the claim, and that a copy will be provided to you upon request at no charge.
6. For a health claim, an explanation of any scientific or clinical judgment, relating to medical necessity or experimental treatment or similar exclusion or limit, which was

the basis for the claim denial, or a statement that such an explanation is available upon request and free of charge.

Claim Denial Review/Appeal

If you receive notice that your claim for Life Insurance, Supplemental Dental or Vision Benefits, or Accident and Sickness Insurance has been denied in full or in part you are entitled to apply for a review of your denied claim.

- Life Insurance: If a claim for the life insurance benefit is denied in whole or in part, the beneficiary can request a review of the claim by Aetna in accordance with Aetna's procedures for appealing a denial of a claim, as contained in the applicable materials from Aetna, such as a summary of benefits and/or subscriber certificate. The notice of decision denying the claim should contain the appropriate instructions for appeal. If you have any questions about obtaining copies of the claim review or appeal procedures, please contact the Plan Administrator.

- Supplemental Dental and Vision Benefits: If your claim for supplemental dental or vision benefits is denied, you should file a request for review or appeal of the denial by writing to the Plan administrator with an explanation of the basis for your request for review.

- Accident and Sickness Insurance: If your claim for benefits is denied in whole or in part, or if you disagree with the decision made on the claim, you may ask for a review or appeal of the denied claim in accordance with Met Life's claim review or appeal procedures, as contained in the applicable summary of benefits and/or subscriber certificate from MetLife. If you have any questions about obtaining copies of the claim review or appeal procedures, please contact the Plan Administrator.

Generally, under federal law, you have 180 days from the date you received the denial of your claim to file a written request for review or appeal. You have the right to submit additional information relating to your claim and appeal, whether or not such information was submitted or considered in the initial benefit determination.

You also have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the insurer on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not be the subordinate of the person who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the

basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment, a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

The decision on any review of your appeal by the insurer or the Plan will be given to you in writing. If your appeal involves a post-service dental or vision claim, the Plan will decide the claim within 60 days following receipt of your written appeal. If your appeal involves a sickness and accident (disability) claim, the insurer will notify you of its decision within 45 days following receipt of your written appeal, unless an extension is needed. (A 45-day extension will be allowed if special circumstances are present, with notice to you if the extension is necessary). The notice of a denial of an appeal will state:

1. The specific reason(s) for the determination
2. Reference to the specific plan provision(s) on which the determination is based
3. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
4. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
5. If an internal rule, guideline or protocol was relied upon by the insurer, you will receive either a copy of the rule or a statement that such rule was relied upon in deciding the claim, and that a copy will be provided to you upon request at no charge.
6. If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

CONTINUATION OF BENEFITS – COBRA

This section contains important information about your right and your Qualified Dependent(s) right to continue your supplemental **Dental and Vision Benefits** temporarily under the Plan under the Consolidated Omnibus Budget Reconciliation Act (COBRA) when you and your Qualified Dependents would otherwise lose such group health care coverage. You and your Qualified Dependent's right to COBRA coverage is triggered by the occurrence of certain enumerated events called Qualifying Events that result in the loss of coverage under the Plan. Continuation coverage is identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, identical to the coverage provided to similarly situated active Qualified Employees who have not experienced a Qualifying Event.

Please note that you may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Qualified Beneficiaries

In general, a Qualified Beneficiary is any Qualified Employee or Qualified Dependent, who on the day before a Qualifying Event, is covered by the Plan.

Qualifying Events and Length of Continuation Coverage

When Plan coverage is lost due to any of the Qualifying Events listed below, you and each eligible Qualified Dependent may self-purchase group health benefits for certain maximum time periods:

QUALIFYING EVENT	WHO MAY PURCHASE	MAXIMUM LENGTH FOR CONTINUATION
Qualified Employee loses eligibility due to a termination of employment (other than for gross misconduct) or a reduction in hours of employment (including retirement)	Qualified Employee and each eligible Qualified Dependent	18 Months
Qualified Employee becomes entitled to Medicare	Each eligible Qualified Dependent	36 Months
Qualified Employee dies	Each eligible Qualified Dependent	36 Months
Qualified Employee is divorced or legally separated from spouse	Spouse	36 Months
Child ceases to be a Qualified Dependent as defined under the Plan	Qualified Dependent child	36 Months

Taking a leave under the Family and Medical Leave Act (FMLA) does not constitute a Qualifying Event. A Qualifying Event occurs, however, if a Qualified Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of the FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later

date and the Plan provides for the extension of the required periods).

If a Qualifying Event that is a termination of employment or reduction in hours occurs less than 18 months after the date you become entitled to Medicare (Part A, Part B or both), the period of coverage for your Qualified Dependents who are Qualified Beneficiaries will last until 36 months after the date of your Medicare entitlement.

If you marry, have a newborn child, or have a child placed with you for adoption during the period of COBRA Continuation Coverage, that new spouse or dependent child may be enrolled for coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to active Covered Persons. Enrollment must occur no later than 30 days after the marriage, birth or placement for adoption. Adding a spouse or dependent child may cause an increase in the cost of COBRA Continuation Coverage.

The COBRA Election Process

A. The Notice of Qualifying Event. As a Qualified Employee or other Qualified Beneficiary, you are responsible for providing the Plan's COBRA Administrator with timely notice of certain Qualifying Events. You must provide the Plan's COBRA Administrator with notice of the following Qualifying Events within the time limits listed below under "When to Send Notice of Qualifying Event":

1. Your divorce or legal separation.
2. A Qualified Beneficiary ceasing to be covered under the Plan as a dependent child.
3. The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second Qualifying Event could include a Qualified Employee's death, entitlement to Medicare, divorce or legal separation or child losing dependent status.
4. When a Qualified Beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. (As explained later, if the determination is made at any time that an individual is disabled during the first 60 days of COBRA coverage, the Qualified Beneficiary may be eligible for an 11-month extension of the 18 month maximum coverage period, for a total of 29 months of COBRA coverage.)
5. When the Social Security Administration determines that a Qualified Beneficiary is no longer disabled.

Providing The Notice: Notice of any of the five situations listed above must be provided in writing and contain the following information: Qualified Employee name, Qualified Beneficiary name, the Qualifying Event listed above for which notice is being provided, and the date of the event.

The notice should be sent to the Plan's COBRA Administrator at the BSA-ILA Health Welfare & Clinic Fund, Charlestown Navy Yard, 197 8th Street, Suite 775 Charlestown, MA 02129.

It may be sent by first class mail.

When to Send the Notice: If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage or a second Qualifying Event, you must send the notice no later than 60 days after the later of (1) the date of the relevant Qualifying Event; or (2) the date upon which coverage would be lost under the Plan as a result of the Qualifying Event. *If you fail to provide notice within the required time period, you may be prevented from obtaining or extending COBRA coverage.*

When the Qualifying Event is any other event, the Employer must notify the Plan's COBRA Administrator of the event within 60 days. The Plan's COBRA Administrator will then notify you and send the election form and information within 60 days of the loss of coverage, or the date you receive the notice, whichever is later. Within 60 days of the event that would cause you to lose your health coverage, you must inform the Plan's COBRA Administrator that you want continuation coverage. No evidence of insurability is required.

If you are providing notice of a Social Security Administration determination of disability, the notice must be sent no later than 60 days after the later of (1) the date of the disability determination by the Social Security Administration; (2) the date of the Qualifying Event; or (3) the date on which the Qualified Beneficiary would lose coverage under the Plan due to the Qualifying Event.

If you are providing notice of a Social Security Administration determination that you are no longer disabled, notice must be sent no later than 30 days after the date of the determination by the Social Security Administration that you are no longer disabled.

These time periods to provide these notices will not begin until you have been informed of the responsibility to provide these notices and these notice procedures through the furnishing of a Summary Plan Description or other general (initial) notice by the Plan.

Persons Who Can Provide the Notice: Notice may be provided by you as the Qualified Employee or by another Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of you or other Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event. For example, if a Qualified Employee, his/her spouse and child are all covered by the Plan, and the child ceases to be a Qualified Dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

If you or your eligible Qualified Dependents have provided notice to the Plan's COBRA Administrator of a divorce or legal separation, a beneficiary ceasing to be covered under the Plan as a dependent, or a second Qualifying Event, but are not entitled to COBRA, the COBRA Administrator will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within 14 days of receiving your notice.

B. Making the Election. Once the Plan's COBRA Administrator sends you your COBRA election materials, you have 60 days to make an election. If you do not choose continuation coverage, your group health insurance coverage will end.

Each Qualified Beneficiary with respect to a particular Qualifying Event has an independent right to elect COBRA continuation coverage. For example, both you, as the Qualified Employee, and your spouse may elect continuation coverage, and only one of you may. A parent or legal guardian may elect continuation coverage for a minor child.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Events listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

C. After Making the Election/Initial Payment. After the Plan's COBRA Administrator receives your election material, you will be notified of the amount of retroactive premium you owe. You will have 45 days from the date you made your COBRA election to make payment for all premiums owed for the period. If payment is not received, COBRA coverage will be cancelled retroactively to the date your coverage under the Plan terminated. You are responsible for making sure that the amount of the payment is correct. You may contact the COBRA Administrator at the address provided above to verify the correct amount of the payment.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of a waiver is an election of COBRA continuation coverage. If a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan's COBRA Administrator.

If a health care provider requests confirmation of coverage and (1) you or your Qualified Dependents have elected COBRA but have not yet paid the premium (and the grace period is still in effect); or (2) you or your Qualified Dependents are within the COBRA election period but have not

yet elected COBRA, COBRA coverage will be confirmed to your health care provider but with notice that the premium has not been paid and that no claims will be paid until the amount due has been received by the Plan's COBRA Administrator. Additionally, your provider will be informed that if the amount due is not received by the end of the grace period, your coverage will terminate retroactively.

D. Monthly Payments. In addition to the retroactive payment described above, you must make a monthly payment to maintain your COBRA coverage. The monthly payments are due on the 1st day of each month. You will have a 30-day grace period in which to pay. Payments should be mailed to the Plan's COBRA Administrator at the address below. If you do not make payment by the end of the grace period, your coverage will be cancelled retroactively to the last day of the previous month.

The Cost of COBRA Coverage

A Qualified Beneficiary may be required to pay the entire cost of continued group coverage at group rates. In most cases the cost will not exceed 102% of the cost of these benefits to the Plan. If the Qualified Beneficiary is eligible for extended COBRA coverage due to a disability (as determined by the Social Security Administration), the cost may be increased to up to 150% of the cost of continued group coverage from the 19th though the 29th month of coverage. Specific cost information will be given to you when you become eligible for COBRA continuation coverage.

Changes to Maximum Period of COBRA Continuation Coverage

If you elect continuation coverage, an extension of the maximum time period for coverage may be available if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event to extend the period of continuation coverage.

- **Multiple Qualifying Events**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed within that 18 or 29-month period by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months. The total period of coverage for any Qualified Dependent will never exceed 36 months from the date of the first Qualifying Event. For example, if you terminated employment and elected COBRA continuation coverage for 18 months for you and your Qualified Dependents, and died during that 18-month period, the continuation coverage for your spouse and/or dependent child(ren) could be extended for the balance of 36 months from the date your employment terminated.

If, however, you are a Qualified Employee who becomes entitled to Medicare while actively at work and later experience a Qualifying Event (such as a termination of employment or reduction in hours), your Qualified Dependents will be entitled to COBRA continuation coverage

until the later of: (1) 36 months from the date you became entitled to Medicare; or (2) the maximum coverage period for the Qualifying Event (18 months in the case of termination or reduction of hours).

- **Entitlement to Social Security Disability Income Benefits**

If you or your Qualified Dependent is entitled to COBRA continuation coverage for an 18-month period, that period can be extended for the Qualified Beneficiary who is determined to be entitled to Social Security disability income benefits and for any other covered family members, for up to 11 additional months, if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA continuation coverage, or within the first 60 days of COBRA continuation coverage; and
- The disabled Qualified Beneficiary receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration; and
- The Plan's COBRA Administrator is notified in writing of the disability determination on a date that is both within 60 days of the date of the determination and before the end of the original 18-month maximum coverage period.

This extended period of COBRA continuation coverage will end at the earlier of the end of 29 months from the date of the Qualifying Event or the date the disabled Qualified Beneficiary becomes entitled to Medicare.

Reasons Why COBRA Continuation Coverage May Be Terminated Early

The law provides that COBRA Continuation Coverage may be terminated before the end of the maximum coverage period for any of the following reasons:

1. The Plan ceases to provide group health plan coverage to any Qualified Employee;
2. The applicable premium for COBRA Continuation Coverage is not paid on time;
3. The Qualified Employee or Qualified Dependent is or becomes entitled to Medicare (Part A or B, whichever occurs earlier)(except that if the Qualified Employee becomes entitled to Medicare, his or Qualified Dependents may continue coverage for up to 36 months from the date of the initial Qualifying Event);
4. The Qualified Employee or Qualified Dependent is or becomes covered under another group health plan that does not contain exclusion or limitation that applies to any pre-existing condition of that covered person, or by law, may no longer apply its preexisting condition limitation or exclusion to that covered person.
5. The Employer that you, as the Qualified Employee, worked for before the Qualifying Event has stopped contributing to the Plan; and the Employer establishes one or more

group health plans covering a significant number of the Employer's employees formerly covered under the Plan; or the Employer starts contributing to another multiemployer plan that is a group health plan.

Continuation coverage may also be terminated for any other reason the Plan would terminate coverage of a covered person who is not receiving COBRA continuation coverage (such as fraud).

If continuation coverage is terminated before the end of the maximum coverage period, the Plan's COBRA Administrator will send a written notice as soon as practicable following the determination that continuation coverage will terminate. The notice will set out why continuation coverage will be terminated early, the date of termination, and rights, if any, to alternative individual or group coverage.

Other Information about COBRA Continuation Coverage

In order to protect your family's rights, you should keep the Plan's COBRA Administrator informed of any changes in address of family members. You should also keep a copy, for your records, of any notices you send to the Plan's COBRA Administrator.

If you have any questions or need additional information about COBRA coverage, please contact the Plan Administrator at the Fund Office:

BSA-ILA Health Welfare & Clinic Fund
Charlestown Navy Yard
197 8th Street, Suite 775
Charlestown, MA 02129
(617) 242-3303

Coverage Options other than COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

For more information about your rights under ERISA, including COBRA, HIPAA and other laws affecting group health plans, you may contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Boston, MA or visit the EBSA website at www.dol.gov/ebsa.

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your dependents did not elect COBRA during your election period, but are later certified by the DOL for Trade Act benefits or receive pensions managed by the Pension Benefit Guaranty Corporation (PBGC), you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan. Also under the Trade Act eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage.

If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact. The Plan Administrator may also be able to assist you with your questions.

FAMILY AND/OR MEDICAL LEAVE

The federal Family and Medical Leave Act ("FMLA") provides that family and medical leave must be available to eligible employees, based on certain rules. You should check with your employer as to whether you are eligible. If you are eligible, your benefits may continue under the following rules:

During any FMLA leave your employer must maintain your coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during your leave. If you were required to make contributions toward the Plan cost before your FMLA leave, you are obligated to continue to make them during the leave period.

Whether or not you keep your coverage while you are on Family or Medical Leave, if you return to work promptly at the end of that leave, your coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. This is also true for any of your Qualified Dependents who were covered by the Plan at the time you took your leave. Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your Qualified Dependents in the same way they apply to all other employees and their dependents.

To find out more about Family and Medical Leave and the terms on which you may be entitled to benefits, contact the Plan Administrator.

SUBROGATION

The BSA-ILA Health, Welfare and Clinic Fund is not obligated to pay benefits or claims in those circumstances where a third party is liable for the injury giving rise to the claim for benefits. The Fund may withhold payment of benefits payable in connection with accidental injuries when any

party other than the covered person or this Fund may be liable for expenses, until such liability is legally determined.

The Fund, in its sole discretion, may make payment of benefits before a finding of liability is made, subject to the agreement of the covered person and his or her counsel, if any, to hold any proceeds of litigation, settlement, or judgment in trust for the Fund and to acknowledge that the proceeds are a plan asset. Payment may be conditioned upon receipt of a subrogation and constructive trust agreement or similar document signed by the covered person and his or her legal representative. In the event of any payment for services under this Plan, the Fund shall, to the extent of such payment, be subrogated to all the rights of recovery of the covered person, and shall be entitled to immediate payment of amounts due before any distribution to or on behalf of the covered person. The covered person will be required to reimburse the Fund for any and all benefits paid under the Plan out of any monies recovered as the result of:

- Judgment
- Settlement, or
- Any other cause

Upon receipt by the covered person or the legal representative, the monies recovered shall become an asset of the Fund. The covered person and the legal representative shall hold the monies recovered as a result of judgment, settlement, or any other cause in trust for the Fund. The Fund is entitled to payment in full, without set-off for attorney's fees, of 100% of benefits paid, whether or not the covered person or participant is made whole; without any reduction for legal or other expenses incurred by the covered person in connection with the recovery against the third party or the third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and regardless of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule); and even if the recovery was reduced due to the covered person's negligence (sometimes referred to as "contributory negligence"), or any other common law defense.

The Trustees may, in their sole discretion, compromise the amount due under this provision when, in their judgment, the compromise is more likely to result in a higher recovery for the Fund than if no compromise were made.

The covered person must take such action, furnish such information and assistance, and execute and deliver all necessary instruments as the Fund may require to facilitate the enforcement of its rights. If the covered person fails to cooperate with the Fund in the enforcement of its rights, the Fund may suspend payment of all benefits subject to subrogation, enforce its right to restitution of amounts paid and to equitable enforcement of the Plan, and seek such other legal or equitable relief to which it is entitled. In addition, if the covered person fails to cooperate with the Fund in the enforcement of its rights, the Fund may offset all present and future payments due the covered person

under the Plan against amounts paid pursuant to the Agreement.

This Fund has the right to recover against any proceeds from other sources received in connection with the accident or injury.

USERRA

Under the Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA), you and your Qualified Dependents have the right to continue your dental and vision coverage under the Plan for up to 24 months if you are on a leave of absence for duty in the uniformed services of the United States. This coverage is similar to COBRA coverage, except that COBRA coverage for those in military service is for 18 months. If your leave is for less than 31 days, your premium payment will be the active contribution, rather than the full COBRA premium. For more information, please call the Plan Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

A QMCSO is a court judgment, decree or order (including the approval of a settlement agreement) that creates or recognizes an alternative recipient—such as a child or stepchild—to be eligible under your dental and vision benefits.

The Fund will recognize a QMCSO that (1) provides for child support of your child/ren under those benefits, (2) provides for health coverage to your child/ren under state domestic relations law (including a community property law) and (3) relates to those dental and vision benefits.

The Fund has procedures for determining whether an order is a QMCSO. You and each alternative recipient will be notified if the Fund receives an order which applies to your benefits. You will also receive a copy of the order and of the Fund's procedures for determining whether it qualifies as a QMCSO.

COORDINATION OF BENEFITS

If you or your Qualified Dependent is entitled to benefits under any other plan which will pay part or all of the expenses incurred for any benefits received or services rendered under this Plan, the amount of benefits payable under this Plan and/or any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred. However, in no event will the amount of benefits paid under the Plan exceed the amount which would have been paid if there were no other plan involved.

The term "plan" refers to any plan providing benefits or services for hospital, medical or dental or vision care or treatment, that is: (a) group or blanket insurance coverage, (b) group and other prepayment coverage provided on a group basis, (c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization

plans or any other arrangement of benefits for individuals of a group and (d) any coverage under governmental programs, and any coverage required or provided by any statute.

When duplicate coverage arises, and both plans contain a Coordination of Benefits provision, the plan that insures the person incurring the claim as an employee is the primary plan. If an individual is insured under two plans through two jobs, the plan which has insured him for the longer period of time pays first.

If a claim is filed for a dependent child, the group plan that insures the parent whose birth date (month and day) occurs first in the calendar year is primary. When another plan does not contain a Coordination of Benefits provision, it will always be considered the primary plan. Payment under the secondary plan is made after the amount payable under the primary plan has been determined.

If two or more plans cover a child as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. first, the plan of the parent with legal custody of the child;
b. then the plan of the spouse of the parent with custody of the child; and
c. finally, the plan of the parent not having custody of the child.

If a court order makes one parent financially responsible for the dental or vision care expenses of the child, however, that parent's plan will pay first. A copy of the court order must be furnished to the Plan Administrator.

If the Plan Administrator has made payment of any amount that is in excess of that permitted by the Coordination of Benefits rules, the Fund has the right to recover such amount from any party that has received such overpayment.

PROTECTED HEALTH INFORMATION USE OR DISCLOSURE

The Fund and the Fund's Board of Trustees ("Plan Sponsor") may only use and/or disclose Protected Health Information (as such term is defined in 45 C.F.R. &164.501) as permitted by the "Standards for Privacy of Individually Identifiable Health Information" under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), P.L. 104-191, and applicable guidelines (the "Privacy Rule"). Additionally, the Fund and the Plan Sponsor must comply with applicable requirements of the HIPAA Security Rule ("Security Rule"), 45 CFR Parts 160, 162 and 164, which applies to the use and/or disclosure of electronic Protected Health Information that the Plan Sponsor receives, creates, maintains or transmits on the Fund's behalf.

Under HIPAA and the Privacy and Security Rules, the Fund will be permitted by law to make certain types of uses or disclosures of your dental and vision information, without your authorization, for payment, treatment and health care operations, as those terms are defined in HIPAA and the Privacy Rule. You have certain rights to request restrictions on certain uses and disclosure of this information, request an amendment of the information, and request an accounting of disclosures, among other things. More detailed information about permitted uses and disclosures of dental and

vision information by the Fund, including examples of permitted uses and disclosures, is contained in the Fund's Notice of Privacy Practices.

In accordance with HIPAA and the Privacy and Security Rules, the Plan Sponsor will:

1. Not use or further disclose Protected Health Information other than as permitted or required by this plan document or as required by law;

2. Ensure that any agents, including a subcontractor to whom they provide Protected Health Information received from the Fund agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; and ensure that any agent or subcontractor to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information;

3. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Fund any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures permitted by the Rule of which it becomes aware;

5. Make available Protected Health Information based on HIPAA's access requirements in accordance with 45 C.F.R. 164.524;

6. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. 164.526;

7. Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

8. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Fund available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with the Rule;

9. If feasible, return or destroy all Protected Health Information received from the Fund that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

10. Ensure that adequate separation of the Fund and Plan Sponsor is established as required by 45 C.F.R. 164.504 (f)(2)(iii), as described below.

11. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan; and

12. Report to the Fund any Security Incident, as defined by the Security Rule, of which it becomes aware.

The Fund, or a health insurance issuer or HMO with respect to the Fund, may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of: (a) obtaining premium bids from health plan providers for providing health insurance coverage under the Fund; or (b) modifying, amending or terminating the Fund.

Certification of Plan Sponsor

The Fund (or a health insurance issuer or HMO with respect to the Fund) shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to the conditions of disclosure set forth above. The Fund shall not disclose and may not permit a health insurance issuer or HMO to disclose Protected Health Information to a Plan Sponsor as otherwise permitted herein unless the statement required by 45 C.F.R. 164.520 (b)(1)(iii)(C) is included in the appropriate notice.

Separation of Plan Sponsor

Only the following types of persons and employees under the control of the Plan Sponsor will be given access to the Protected Health Information: Fund Trustees, Fund Legal Counsel, Fund Administrator, Fund administrative personnel, Fund Privacy Officer. Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Fund in the ordinary course of business, will also be included in the definition above of Permitted Persons or Employees. The Permitted Employees or Persons may only use the Protected Health Information for Fund administrative functions that the Plan Sponsor performs for the Fund.

BSA-ILA HEALTH AND WELFARE FUND
NOTICE OF PRIVACY PRACTICES

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.

Protected Health Information (PHI) is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition, in the past, present or future. This Notice of Privacy Practices describes how the BSA-ILA Health and Welfare Fund ("Plan" or "we") may use and disclose your PHI. It also describes your rights to access and control your PHI.

As a group health plan, we are required by federal law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices. If State law is more restrictive than Federal law in any of these areas, the more strict State law will be followed.

We are required to abide by the terms of this Notice of Privacy Practices, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that we are maintaining at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals covered under the Plan at that time. In addition, you will be notified at least once every three (3) years of the availability of this Notice and how you can obtain a copy.

PERMITTED USES AND DISCLOSURES

Treatment, Payment and Health Care Operations

Federal law allows a group health plan to use and disclose PHI, for the purposes of treatment, payment and health care operations, without your authorization. Examples of the uses and disclosures that we, as a group health plan, may make under each section are listed below:

- *Treatment.* Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. As a group health plan we do not provide treatment.

- *Payment.* Payment refers to the activities of a group health plan in collecting premiums and paying claims under the plan for health care services you receive. Examples of uses and disclosures under this section include the sending of PHI to an external medical review company to determine the medical necessity or experimental status of a treatment; sharing PHI with other insurers to determine coordination of benefits or settle subrogation claims; providing PHI to the group health plan's utilization review company for pre-certification or case management services; providing PHI in the billing, collection and payment of premiums and fees to plan vendors such as PPO Networks, utilization review companies, prescription drug card companies and reinsurance carriers; and sending PHI to a reinsurance carrier to

obtain reimbursement of claims paid under the Plan. For example, we may disclose your PHI to obtain payment in an automobile subrogation case.

- *Health Care Operations.* Health Care Operations refers to the basic business functions necessary to operate a group health plan. Examples of uses and disclosures under this section include conducting quality assessment studies to evaluate the plan's performance or the performance of a particular network or vendor; the use of PHI in determining the cost impact of benefit design changes; the disclosure of PHI to underwriters for the purpose of calculating premium rates and providing reinsurance quotes to the plan; the disclosure of PHI to stop-loss or reinsurance carriers to obtain claim reimbursements to the group health plan; disclosure of PHI to plan consultants who provide legal, actuarial and auditing services to the group health plan; and use of PHI in general data analysis used in the long term management and planning for the plan and company. For example, we may disclose your PHI in our attempt to obtain adequate stop loss insurance for the fund as a whole.

- *Health Services.* The Plan may use your PHI to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan may disclose your PHI to its Business Associates to assist the Plan in these activities.

Other Uses and Disclosures Allowed Without Authorization

Federal law also allows a group health plan to use and disclose PHI, without your authorization, in the following ways:

- To you, as the covered individual.
- To a personal representative designated by you to receive PHI such as a friend or relative or a personal representative designated by law such as the parent or legal guardian of child, or the surviving family members or representative of the estate of a deceased individual.
- To the Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine our compliance with the HIPAA Privacy Rules.
- To a Business Associate as part of a contracted agreement to perform services for the group health plan. Each Business Associate must agree in writing to ensure the continuing confidentiality and security of your medical information.
- For research purposes in limited circumstances.
- To a health oversight agency, such as the Department of Labor (DOL), the Internal Revenue Service (IRS) and the Insurance Commissioner's Office, to respond to inquiries or investigations of the Plan, requests to audit the Plan, or to obtain necessary licenses.
- In response to a court order, subpoena, discovery request or other lawful judicial or administrative proceeding.
- As required for law enforcement purposes. Such permitted disclosures include the following to: law enforcement officials for limited law enforcement purposes; a coroner, medical examiner, or funeral director about a deceased person; an organ procurement organization in

limited circumstances; federal officials for lawful intelligence, counterintelligence and other national security purposes; public health authorities for public health purposes; appropriate military authorities, if you are a member of the armed forces

- As required to comply with Workers' Compensation or other similar programs established by law.
- To the Trustees, as necessary to carry out administrative functions of the Plan such as evaluating renewal quotes for reinsurance of the Plan, funding check registers, reviewing claim appeals, approving subrogation settlements and evaluating the performance of the Plan.
- In providing you with information about treatment alternatives and health services that may be of interest to you as a result of a specific condition that the Plan is case managing.

The examples of permitted uses and disclosures listed above are not provided as an all inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.

OTHER USES AND DISCLOSURES

Other uses and disclosures of your PHI will only be made upon receiving your written authorization. The types of uses and disclosures that require your authorization include:

- the use and disclosure of psychotherapy notes, except by the originator of the notes for treatment, by the Fund for its own supervised training programs, or by the Fund to defend itself in a legal proceeding;
- the use and disclosure of PHI for marketing, except if the communication is in the form of a face-to-face communication by the Fund to an individual or a promotional gift of nominal value by the Fund; and
- the disclosure of PHI which is a sale of PHI as defined by HIPAA regulations.

You may revoke an authorization at any time by providing written notice to us that you wish to revoke an authorization. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in good faith with the authorization.

YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

Right to Request Restrictions on Uses and Disclosures

You have the right to request that the Plan limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request the Plan restrict the use or disclosure of your PHI to family Members or personal representatives. Any such request must be made in writing to the Privacy Contact listed below and must state the specific restriction requested and to whom that restriction would apply.

The Plan is not required to agree to a restriction that you request. However, if it does agree to the requested restriction, it may not violate that restriction except as necessary to allow the provision of emergency medical care to you.

Right to Receive Confidential Communications

You have the right to request that communications involving PHI be provided to you at an alternative location or by an alternative means of communication. The Plan is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Contact listed in this Notice.

Right to Access to Your Protected Health Information

You have the right to inspect and copy your PHI that is contained in a designated record set for as long as the Plan maintains the PHI. A designated record set contains claim information, premium and billing records and any other records the Plan has created in making claim and coverage decisions relating to you. Federal law does prohibit you from having access to the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed. Requests for access to your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Amend Protected Health Information

You have the right to request that PHI in a designated record set be amended for as long as the Plan maintains the PHI. The Plan may deny your request for amendment if it determines that the PHI was not created by the Plan, is not part of designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and the Plan has a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Have an Opportunity to Object to Uses and Disclosures

Unless you object, the Plan may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, the Plan may disclose such information as necessary if it determines that it is in your best interest based on our professional judgment.

The Plan may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. The Plan

will provide you with an opportunity to agree or object to such a disclosure whenever it practically can do so.

Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of all disclosures of your PHI that the Plan has made, if any, for reasons other than disclosures for treatment, payment and health care operations, as described above, and disclosures made to you or your personal representative. Your right to an accounting of disclosures applies only to PHI created by the Plan after April 14, 2003 and cannot exceed a period of six years prior to the date of your request. Requests for an accounting of disclosures of your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Receive a Paper Copy of this Notice

You have the right to receive a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. Requests for a paper copy of this Notice should be directed to the Privacy Contact listed in this Notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of Health and Human Services. Complaints should be filed in writing with the Privacy Contact listed in this Notice. You will not be retaliated against you for filing a complaint.

PRIVACY CONTACT

If you have any questions about this Notice, or you wish to make a complaint, please contact the Privacy Officer for the Plan: Dennis Miniscalco, BSA-ILA Health Welfare & Clinic Fund, Charlestown Navy Yard, 197 8th Street, Suite 775, Charlestown, MA 02129, (617) 242-3303.

OTHER IMPORTANT INFORMATION

Plan Number: 501
Employer Identification No.: 04-6063728
Type of Plan: Welfare Plan

Plan Administrator

The Plan is administered by a Board of Trustees, which is comprised of 14 members, and is the Plan Administrator. Seven members are appointed by the participating Boston Shipping Association Employers, and seven are appointed or elected by the participating local unions, the International Longshoremen's Association AFL-CIO and the Atlantic Coast District.
The Trustees may be contacted by writing to them at:

Trustees, BSA-ILA Health Welfare & Clinic Fund
Charlestown Navy Yard
197 8th Street, Suite 775
Charlestown, MA 02129
(617) 242-3303

The members of the Board of Trustees are:

Boston Shipping Association Trustees:

William C. Eldridge
Mediterranean Shipping Co. Boston
8 Essex Center Dr. – 3rd Floor
Peabody, MA 01960

Michael Meyran
Massport
1 Harborside Drive-Suite 200
E. Boston, MA 02128

Richard F. Meyer
Boston Shipping Association, Inc.
197 Eighth Street, Suite 775
Charlestown, MA 02129

David Powell
C. H. Powell Co.
75 Shawmut Road
Canton, MA 02021

Stefan Palmer
Moran Shipping Agencies, Inc.
11 Elkins Street, Suite 240
South Boston, MA 02127

William Weigele
Columbia Coastal Transport
95 Fargo Street
South Boston, MA 02210

Ryan Cox
Boston Line & Service
One Black Flacon Avenue
Boston, MA 02210

International Longshoremen's AFL-CIO Trustees:

William McNamara
ILA Vice President
399 Pond Street, Apt. D-6
Braintree, MA 02184

Bernard O'Donnell
ACD V.P.
32 Stallion Way
Marstons Mills, MA 02648

William Sullivan (Local 799)
60 George Street
Mendon, MA 02648

George McEvoy III (Local 800)
895 E. Broadway
South Boston, MA 02127

Donald Portalla, Jr. (Local 805)
32 Montmorenci Avenue
East Boston, MA 02128

Robert Walsh (Local 1066)
3 Peabody Avenue
Marblehead, MA 01945

Anthony Farmusa (Local 1604)
34 Admiral's Way
Chelsea, MA 02150

Plan Fiduciaries

The Board of Trustees acts as the fiduciary for the Plan. In addition, the Board has appointed the following parties as fiduciaries regarding the determination of eligibility and delivery of benefits, payment of claims, and review of claims and claim denials with respect to the relevant dental, vision, accident and sickness, and life insurance benefits provided under the Plan:

Aetna Insurance Company:
P.O. Box 14549, Lexington, KY 40512-4549
1-800-523-5065

MetLife Insurance Company:
P.O. Box 14590, Lexington, KY 40511
1-800-300-4296
1-866-213-2249

Plan Funding

The Plan is funded by contributions by the Participating Employers covered under the current Bargaining Agreement between the Boston Shipping Association and the International Longshoremen's Association AFL-CIO.

The funds received by the Plan are invested until such time as they are needed to pay insurance premiums, and the other benefits provided by the Plan.

Plan Contributions

The Participating Employers contribute to the Trust Fund amounts in accordance with the Bargaining Agreement. Plan benefits shall not exceed the amount of contributions to the Trust Fund as provided for in the Bargaining Agreement, plus the surplus of the prior year's fund, should such surplus exist.

While it is the intention of the Board of Trustees, the Participating Employers, and the Union to continue providing the benefits set forth in the Plan indefinitely, if contributions and surplus funds are not sufficient, Plan benefits will be reduced or eliminated, and/or employees will be given the option of continuing such benefits at their own expense.

Plan Records

Plan records are kept as required by applicable law, on a contract year basis starting on October 1 of each year and ending on the following September 30. That period is the Plan Year.

Legal Service

Legal process may be served on the Board of Trustees, which is the Plan Administrator and Plan Sponsor, at the following address: BSA-ILA Health Welfare & Clinic Fund, Charlestown Navy Yard, 197 8th Street, Suite 775, Charlestown, MA 02129.

Plan Continuation

The Board of Trustees, the Participating Employers and the Union hope and expect to continue the Plan indefinitely. The right is necessarily reserved by the Trustees to amend and modify the Plan at any time. The Participating Employers and the Union reserve the right to terminate the Plan.

If the Plan is terminated, you and your Qualified Dependent(s) or beneficiary(ies) will not have any further rights, other than the payment of benefits for an event that occurred before the Plan was terminated. The amount and form of any final benefit you receive will depend on any contract provisions affecting the Plan, and decisions of the Board of Trustees.

After all benefits have been paid and other requirements of the law have been met, any remaining Plan assets will be, at the discretion of the Board of Trustees, either used to purchase benefits or distributed to Plan participants, in accordance with the requirements of law.

YOUR ERISA RIGHTS

As a participant in the Boston Shipping Association International Longshoremen's Association Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- ☐ Examine, without charge, at the Plan Administrator's office and other Employer locations, all Plan documents governing the Plan and filed by the Plan with the U.S. Department of Labor, including pertinent insurance contracts, annual reports and Plan descriptions.

- ☐ Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the

copies.

- Receive a Summary Annual Report of the Plan's financial activities. The Plan Administrator is required by law to furnish each Plan participant with a copy of the Summary Annual Report each year.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries, have a duty to do so prudently and in the interest of Plan participants.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called ``fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights.

- For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

- In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

- If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

In witness, whereof, the undersigned Trustees have executed this Plan document as of this 30th day of April 2015.

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