



The
MILA

National Health Plan

.....
YOUR HEALTH CARE BENEFITS
SUMMARY PLAN DESCRIPTION

About This Book

This book is the Summary Plan Description (SPD) for your health care benefits. Every effort has been made to ensure that the information presented is accurate. However, the benefits summarized in this book are governed by the official Plan Document. If there is any conflict between the information presented in this book and the official Plan Document, the Plan Document will prevail.

This book does not represent a promise of benefits nor does it represent that you are eligible for benefits. No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned the right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed. In addition, the 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.

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each benefit program of the Plan have full discretionary authority to (1) interpret the terms of the Plan, to resolve ambiguities, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan and (2) make all factual determinations arising under the Plan and in connection with any claims for benefits thereunder, and applying the facts to the terms of the Plan.

Any review of a final decision or action of the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each benefit program of the Plan shall be based only on such evidence presented to or considered by them at the time they made the decision that is the subject of review. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Note: For purposes of meeting the Essential Health Benefits requirement of the Patient Protection and Affordable Care Act, the Board of Trustees has adopted the Utah benchmark plan, pursuant to federal regulation 45 CFR 156.100.



NATIONAL HEALTH PLAN

THE MILA National Health Fund

The Trustees of the Management–International Longshoremen’s Association (MILA) Managed Health Care Trust Fund, with equal representation from management and labor, have established the MILA National Health Plan (Plan) as the health care plan to provide medical, behavioral health, prescription drug, dental and vision benefits for eligible active and retired employees and their qualified dependents who are covered under the Master Contract. The Master Contract has been negotiated between the International Longshoremen’s Association, AFL-CIO (ILA), and employers represented by the United States Maritime Alliance, Ltd. (USMX). The Plan also covers certain other non-bargaining unit employees as recognized by the Trustees.

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This book is the Summary Plan Description (SPD) for the MILA National Health Plan (Plan). It will provide you with detailed information about the Plan and its many benefits, including medical coverage, dental coverage, vision coverage, behavioral health coverage (including the Member Assistance Plan and treatment for mental illness and substance abuse), and prescription drug coverage. You should read the sections which affect your benefit coverage; share the SPD with your family; and keep it in a safe place for future reference.

Active Members and their eligible dependents generally will be covered during the calendar year in the Premier, Basic or Core Plan depending upon the credited hours which the Member earned during the prior Contract Year, which expires each year on September 30th. Pensioners and their eligible dependents who qualify for health plan benefits in retirement based upon the rules explained later in this book will be covered in the Premier or the Basic plan until they are eligible to enroll for Medicare benefits. Thereafter, they will be covered in the MILA Medicare Wrap-Around plan.

Overview Of The MILA National Health Plan

Medical, behavioral health and prescription drug expenses are uniformly covered in all four benefit plans (Premier, Basic, Core and MILA Medicare Wrap-Around plans) because the MILA National Health Plan is a single unified program. This uniform coverage applies to all expenses, unless the Plan specifically states that there is a difference. The main difference between the benefit plans is your portion of the benefit expense when a covered charge is incurred. For example, deductibles, coinsurance, and copays differ from benefit plan to benefit plan. In addition, the Basic and Core plans only cover In-Network medical and behavioral health benefits. Similarities exist in the following broad general areas of the program:

- **The Plan is self-insured.** It is funded by contributions that have been made by employers who are parties to the Master Contract in compliance with the terms of that contract. Additional contributions have been made by Participation Agreement employers at a rate determined by the MILA Trustees and by COBRA participants. All contributions are held in trust in the MILA Managed Health Care Trust Fund for the sole and exclusive benefit of MILA participants and their beneficiaries as determined by the Plan.
- **Benefits provided by network contracted providers (known as network benefits) are the same in all benefit plans**—doctors, hospitals, laboratories and testing facilities, behavioral health counselors, and pharmacies.
- **The Claims Administrators are as follows:** Cigna manages medical networks and claims, Aetna manages dental networks and claims, EyeMed manages vision networks and First American Administrators (FAA), a wholly owned subsidiary of EyeMed Vision Care, manages vision claims, Cigna Behavioral Health (CBH) manages behavioral health networks and claims, and CVS Caremark manages prescription drug networks and claims.

Please note that dental and vision benefits are treated as standalone (or excepted) benefits under the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA) because they are administered under a contract separate from claims administration for any other benefits under the Plan.

- **The Member Assistance Plan (MAP) provides a broad set of programs to assist Plan participants with a whole range of issues.** Many people think of the MAP as providing the main access point for the Behavioral Health programs. Although this is true, one can also access the Behavioral Health program directly by calling a provider or through

referral from your medical provider. However, the MAP can also help with many other problems. For example, it can provide information about child care and elder care providers, it can help with financial counseling on a whole range of issues from mortgage selection and evaluation to budgeting and household financial management, and it can assist with marriage counseling and workplace problem resolution. Many other issues may also be addressed by the MAP counselors. Any person in your household may access the MAP directly by calling the MAP counselor. If you are uncertain as to whether a particular problem might be addressed by the MAP, call a MAP counselor, and ask.

- **Covered charges and benefit exclusions are the same throughout the program except:**
 - In the Premier plan and the MILA Medicare Wrap-Around plan, medical and behavioral health benefits are covered both In-Network and Out-of-Network.
 - In the Basic and Core plans, only In-Network medical and behavioral health benefits are covered.
 - In the MILA Medicare Wrap-Around plan, Medicare provides the network as the primary payer of benefits except in the extremely rare circumstances when Medicare does not cover the service or supply, but the Plan does.
- **Plan benefit limits apply throughout the program.** If you change benefit plans during the year, annual plan limits transfer into the new benefit plan. This happens infrequently, but it might happen if you retire or if your dependent loses eligibility and elects COBRA continuation coverage in another lower cost benefit plan.
- **The requirements for medical management are the same in the Premier, Basic and Core plans**—that is, the requirements for precertification of:
 - a medical procedure or service;
 - an admission to a hospital or other institution,
 - for concurrent review of a hospital or institutional confinement by the appropriate Claims Administrator; and
 - for prior authorization of a limited number of prescription drugs.
- **In the MILA Medicare Wrap-Around plan, Medicare procedures govern when Medicare covers a service or supply. Otherwise, MILA's Claims Administrator's procedures apply.**

Affordable Care Act (ACA) — Important Information

The MILA Trustees believe the Premier plan, the Basic plan, and the Core plan are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your benefit plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to MILA's Executive Director at 212-766-5700. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or access information online at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

SPD Sections

This SPD has been designed to provide you with ready access to the information to which most people refer while still satisfying the requirement to be a complete source of information about the program. It is organized as follows:

- **Section I: Benefit Summaries**—reviews each benefit plan offered by MILA and provides an outline of your costs when you participate in a specific benefit plan.
- **Section II: Understanding What is Covered**—supplies a detailed description of what is covered under the Plan, including the limitations on that coverage.
- **Section III: Understanding What is Not Covered**—supplies a detailed description of what is not covered under the Plan and how this Plan will coordinate its benefits when you are covered by another benefit plan in addition to this Plan. It also discusses how this Plan will recover its cost of benefits under the Plan’s subrogation and reimbursement procedures.
- **Section IV: Participation Under the Plan**—provides information on who is eligible for coverage, when coverage begins, when coverage ends, and what steps you must take if you wish to elect COBRA Continuation Coverage.
- **Section V: Claims and Appeals**—discusses claim submission procedures and the steps which you must follow in order to have an adverse claim decision reviewed by a Claims Administrator.
- **Section VI: Your Rights Under ERISA**—contains information regarding your right to coverage under the Plan and your rights under ERISA and to remedies available to you in the event you believe that your rights have been violated.
- **Section VII: Administrative Information**—gives a listing of contact information for MILA and the Claims Administrators.
- **Section VIII: Glossary**—is a list of terms used in this SPD. Terms used in health plans are similar to those we use every day, but in this Plan, these terms have a very specific meaning.

Questions

If you have questions about whether you are eligible for coverage or when coverage will begin or end, you may address those questions to MILA at 212-766-5700. Questions about what is covered and how one might access coverage should be addressed to the Claims Administrators (the telephone numbers for the Claims Administrators can be found on the back of your ID cards) or to MILA at 212-766-5700.

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MILA Premier Plan

Benefits Summary

Shown below is the MILA Premier Plan Benefits Summary for eligible active Members, and for those Pensioners age 62 or older who are not yet eligible to enroll for Medicare. This chart allows you to see at a glance the key plan features. The copay, deductible, and coinsurance amount below reflect what you pay. MILA pays the balance of covered charges.

Summary Of The MILA National Health Plan: Premier Benefits		
	Premier	
Features	In-Network	Out-Of-Network
Calendar Year Deductible —This deductible applies to both medical and behavioral health benefits.		
Individual	None	\$300
Family Limit	None	\$600
Annual Out-of-Pocket Maximum —This maximum includes your deductible and coinsurance payment for medical and behavioral health benefits.		
Individual	None	\$6,500
Family Limit	None	\$13,000
No Lifetime Maximum Benefit		
Physician Services Copay/Visit		
Primary Care Physician (PCP)	\$15 copay/visit	40% of R&C* after deductible plus excess over R&C
Specialist Physician	\$30 copay/visit	40% of R&C after deductible plus excess over R&C
Short-Term Rehabilitation (STR)	\$10 copay/visit	40% of R&C after deductible plus excess over R&C
Behavioral Health Provider	\$15 copay/visit	40% of R&C after deductible plus excess over R&C
Preventive Care	\$15 copay/visit	In-Network Only
Maternity Care (one/pregnancy)	\$15 copay/pregnancy	40% of R&C after deductible plus excess over R&C
Hospital Care		
Hospital Inpatient Care including professional services (Precertification Required)	\$0 (Paid in full by Plan)	40% of R&C after deductible plus excess over R&C
Hospital Outpatient Surgery/Testing	\$0 (Paid in full by Plan)	40% of R&C after deductible plus excess over R&C
Emergency Room (emergency only/waived if admitted)	\$25 copay/visit	Treated as In-Network
Urgent Care Center	\$25 copay/visit	40% of R&C after deductible plus excess over R&C
Ambulance	\$0 (Paid in full by Plan)	40% of R&C after deductible plus excess over R&C
Skilled Nursing (up to 100 days per the calendar year)	\$0	40% of R&C after deductible plus excess over R&C
Home Health Care—(Includes up to 120 visits per the calendar year.) Visits include part-time or intermittent nursing care or for care supervised by an RN, part-time or intermittent services of a home health aide and visits for physical, occupational or speech therapy.	\$0	40% of R&C after deductible plus excess over R&C
Prescription Drug		
	In-Network	Out-Of-Network
Prescription Brand Deductible per Family	\$500 Deductible applies to all Brand Name Drugs when a generic equivalent is available	
Retail		
Retail Copay—up to 30-day supply (Generic)	\$5	\$5
Retail Copay—up to 30-day supply (Preferred Brand)	\$10	\$10
Retail Copay—up to 30-day supply (Non-Preferred Brand)	\$25	\$25
For Retail: Up to 30-day supply—First fill plus one refill per prescription		Plus excess over contract cost
Maintenance Choice or Mail Order		
Mail Order Copay—up to 90-day supply (Generic)	\$5	NOT COVERED
Mail Order Copay—up to 90-day supply (Preferred Brand)	\$15	
Mail Order Copay—up to 90-day supply (Non-Preferred Brand)	\$50	
For Mail Order & Maintenance Choice: Up to 90-day supply		

*R&C means the reasonable and customary charges as defined in the Glossary at the back of this SPD.

In-Network Services

Each Claims Administrator has In-Network providers for the use of Plan Participants.

- The Cigna network is a broad-based provider network from which you may select any participating physician, hospital, or other provider if that provider has been contracted for the service. For example, you might select a cardiologist to treat heart ailments.
- The Cigna network includes in-store health clinics in select locations under the brand names of:
 - Little Clinic in Kroger and Publix Stores;
 - Minute Clinic Health Care Centers in CVS Pharmacies and elsewhere;
 - Redi Clinic;
 - Take Care Clinic;
 - CVS MinuteClinic inside Target;
 - Wal-Mart Care Clinic;
 - CMG CareToday Clinics.

These clinics generally offer extended hours of operation (open 24 hours) and do not require appointments. They generally see patients within one-half hour or less. They offer limited services in the treatment of minor illness or injury, and the services are performed by nurse practitioners under the direction of a staff physician—all for a primary care copay of \$15.

- The Cigna network of behavioral health providers includes psychiatrists, psychologists, certified psychological counselors, and other appropriate professionals. You may select any In-Network provider with the appropriate credentials for treatment.
- The CVS Caremark network of pharmacies includes all the retail pharmacies with which CVS Caremark has a contract. If the CVS Caremark logo is displayed, the retail pharmacy is available to you. CVS Caremark offers MILA participants mail order services exclusively through the CVS Caremark mail-order system. As an alternative, CVS Caremark offers the Maintenance Choice program, which enables mail-order prescriptions up to 90 days to be filled at CVS retail pharmacies.

Although you are responsible for complying with the Plan's medical management procedures, In-Network providers gen-

erally are familiar with these procedures and will assist you in this process.

The In-Network providers have been selected based upon that provider's credentials and the quality of service which those provider have delivered in the past. Quality service always creates a more satisfactory experience for you and generally will result in a lower cost to the Plan. The provider must agree as a condition of participation to give the network a discount on the cost of service. However, quality service is the most important contributor to lower Plan cost. If the service is appropriate to your medical needs, you will recover faster and require fewer medical services. Not only will this result in lower total Plan cost, but it will create a more satisfactory experience for you.

Out-Of-Network Services

From time to time, you may want to use a non-network provider. The Premier plan provides coverage for the Out-of-Network service. However, this type of service generally will result in a higher cost to you and the Plan for the following reasons:

- Not only will you have to pay the deductible and coinsurance identified and itemized in the Premier Plan Benefits Summary, but the provider's charges will generally be higher because those charges generally are not discounted.
- If the provider's charges exceed the reasonable and customary charge for the procedure as determined by MILA's Claims Administrator, the Plan will not consider this excess cost in calculating its reimbursement, and you will have to pay this additional cost.
- In-Network providers generally follow medical procedures that have been certified as effective by the provider's Medical Board.

- If you use an Out-of-Network pharmacy, you may incur additional expenses because MILA will reimburse you for no more than it would have paid the highly discounted In-Network pharmacies for each drug. See page 41 for more information.
- If you use an Out-of-Network provider, you will be responsible for ensuring that your provider follows all Plan medical management procedures in pre-certifying your care, your hospitalization or other institutional care, and in securing any necessary prior authorization for prescription drugs.

You should attempt to use In-Network providers whenever possible in order to be assured of receiving the highest quality medical service at the lowest possible cost to you and your family.

In-Network Plan Benefits

In-Network benefits are subject to a copay when you visit a physician for service. The copay amounts are as follows:

- \$15 for a Primary Care Physician (PCP) or an in-store health clinic;
- \$30 when you visit a Specialist;
- \$15 for Psychological Counseling;
- \$25 for Hospital Emergency Room visits, but this copay will be waived if the individual is admitted; and
- \$10 for Short-Term Rehabilitation (STR) visits (see the explanation below).

Short-Term Rehabilitation (STR)—The Premier plan contains a special lower copay, which applies when you seek STR therapy. This lower copay applies to visits to providers who treat you with this therapy because the therapy frequently involves several visits and the completion of the course of therapy is often necessary in order to achieve the desired result. Physician visits for STR include visits for the following therapies:

- Occupational Therapy;
- Physical Therapy;
- Speech Therapy;
- Cardiac Rehabilitation Therapy;
- Pulmonary Rehabilitation Therapy; and
- Cognitive Therapy.

There is a 60-visit annual limit that applies to all of the visits for the services listed above during the calendar year. For example, if you have 20 visits to an occupational therapist and 40 visits to a physical therapist in the same year, you will have reached the 60-visit limit.

The STR copay also applies for visits to an In-Network chiropractor. There is a separate 60-visit annual limit for chiropractor visits during the calendar year.

In addition, the STR copay applies to diagnostic radiology which includes but is not limited to:

- Diagnostic Mammogram;
- Magnetic Resonance Imaging (MRI);
- PET Scan;
- CAT Scan; and
- X-Ray and Sonogram.
- Note that if a condition has been diagnosed and the purpose of the radiology is for treatment, the regular specialist copay of \$30 will apply instead of the STR copay of \$10.

NOTE

Note that if a condition has been diagnosed and the purpose of the radiology is for treatment, the regular specialist copay of \$30 will apply instead of the STR copay of \$10.

There is no copay when you are hospitalized at an In-Network hospital or have a test or procedure in the outpatient department of an In-Network hospital.

Visits to the emergency room of an In-Network or Out-of-Network hospital for routine (non-emergency) medical treatment are not covered (see page 33 for the definition of an emergency).

Prescription Drug Benefits

Prescription drugs are subject to the copay applicable to the type of drug indicated in the Premier Plan Benefits Summary. If you have a prescription for a brand drug for which there is a generic equivalent drug, the generic drug will be issued, unless the prescribing physician has indicated that substitution

may not occur. In that case, the cost of the prescription may be subject to the \$500 deductible per family each calendar year. See page 38 for more information on the prescription drug deductible and generic drug substitution.

If your physician prescribes a Specialty medication, you must fill that prescription through the CVS Caremark Specialty Pharmacy in order for that prescription to be covered under the MILA Plan. See pages 42–43 for more information on this program.

If you are covered by another prescription drug program in addition to the MILA Plan, notify MILA of your other coverage so your benefits can be coordinated to provide you with the best coverage. See page 43 for more information.

Out-Of-Network Plan Benefits

If you seek treatment from a provider who does not participate in the network, then deductibles and coinsurance will apply. The deductible applies to all medical services. The cost of the service for which you will be responsible under the coinsurance rates is indicated in the Premier Plan Benefits Summary. Generally, you will pay 40% of the reasonable and customary charges for all medical services plus 100% of any excess fee over the reasonable and customary (R&C) amounts as determined by MILA's Claims Administrator.

If you must use the services of a medical provider that does not participate in the Cigna Healthcare Network, show that provider your MILA/Cigna Identification Card, which identifies you as a participant in a Cigna Healthcare Open Access Plus Network. Your ID card also contains the logo for groups of medical providers that do not participate in the Cigna Healthcare Open Access Plus Network but do provide services at a discounted charge. You must show the provider your card in order to qualify for any Out-of-Network discount the provider might offer. **If the provider offers you a discount, both you and MILA will benefit from the reduction in the cost of the service.**

Out-Of-Pocket Expense Maximum

Your total Out-of-Network, out-of-pocket expenses for deductible and coinsurance payments for medical and behavioral health services and supplies is limited to no more than \$6,500 per individual and no more than \$13,000 per family in covered expenses each calendar year. The limit does not include prescription drug deductible or copay expenses.

Out-Of-Area Plans

Most MILA Members live in areas where the network is adequately staffed to their needs. However, the Trustees have decided that certain geographical areas have insufficient Cigna network providers, and, because of this, Members in those areas are eligible for Out-of-Area benefits. You will be notified if you live in such an area and you will receive a special ID card. For persons living in these areas, the Out-of-Network charges have been modified as follows:

- Your deductible is \$150 per individual and \$300 per family.
- Your coinsurance is 20% rather than 40%.
- Your maximum out-of-pocket expense for the deductible and coinsurance during the calendar year is \$2,500 per individual and \$5,000 per family.

In addition, preventive care and family planning are covered services under the Out-of-Area Plan. If you live in an area that has been designated Out-of-Area, you may use In-Network providers and receive all the benefits which they provide. However, if you use Out-of-Network providers, these Out-of-Area Plan adjustments will reduce your cost to do so.

NETWORK REVIEW

Cigna continually reviews its network and recruits providers in areas in which MILA Members live. As a result, the Trustees will reclassify areas as the network becomes sufficiently staffed and Members who live within areas which have been reclassified will be notified.

MILA Basic Plan

Benefits Summary

Shown below is the MILA Basic Plan Benefits Summary for eligible active Members and for those Pensioners ages 58 through 61, who are not eligible for Premier Plan benefits and not yet eligible to enroll for Medicare. This chart allows you to see at a glance the key plan features. The copay, deductible and coinsurance amounts below reflect what you pay. MILA pays the balance of covered charges.

Summary Of The MILA National Health Plan: Basic Benefits		
	Basic Plan	
Features	In-Network	
Calendar Year Deductible — <i>This deductible applies to both medical and behavioral health benefits.</i>		
Individual	\$400	
Family Limit	\$700	
Annual Out-of-Pocket Maximum — <i>This maximum includes your deductible and coinsurance payment for medical and behavioral health benefits.</i>		
Individual	\$5,000	
Family Limit	Not Applicable	
No Lifetime Maximum Benefit		
Physician Services Copay/Visit		
Primary Care Physician (PCP)	\$25 copay/visit	
Specialist Physician	\$40 copay/visit	
Behavioral Health Provider	\$15 copay/visit	
Preventive Care	\$25 copay/visit	
Maternity Care (one/pregnancy)	\$25 copay/visit	
Hospital Care		
Hospital Inpatient Care including professional services (Precertification Required)	\$350 copay/1st Admission each year: 30% of the network charge after deductible	
Hospital Outpatient Surgery/Testing	30% of the network charge after deductible	
Emergency Room (emergency only/waived if admitted)	\$50 copay/visit	
Urgent Care Center	\$25 copay/visit	
Ambulance	30% of the network charge after deductible	
Skilled Nursing (up to 100 days per calendar year)	30% of the network charge after deductible	
Home Health Care—(Includes up to 120 visits per calendar year.) Visits include part-time or intermittent nursing care or for care supervised by an RN, part-time or intermittent services of a home health aide and visits for physical, occupational, or speech therapy.	30% of the network charge after deductible	
Prescription Drug	In-Network	Out-Of-Network
Prescription Brand Deductible per Individual	\$500 Deductible applies to all Brand Name Drugs when a generic equivalent is available	
Retail		
Retail Copay—30-day supply (Generic)	\$5	\$5
Retail Copay—30-day supply (Preferred Brand)	\$10	\$10
Retail Copay—30-day supply (Non-Preferred Brand)	\$25	\$25
For Retail: Up to 30-day supply—First fill plus one refill per prescription		
Maintenance Choice or Mail Order		
Mail Order Copay—90-day supply (Generic)	\$5	NOT COVERED
Mail Order Copay—90-day supply (Preferred Brand)	\$15	
Mail Order Copay—90-day supply (Non-Preferred Brand)	\$50	
For Mail Order & Maintenance Choice: Up to 90-day supply		

In-Network Services

Each Claims Administrator has In-Network providers for the use of Plan participants.

- The Cigna network is a broad-based provider network from which you may select any participating physician, hospital, or other provider if that provider has been contracted for the service. For example, you might select a cardiologist to treat heart ailments.
- The Cigna network includes in-store health clinics in select locations under the brand names of:
 - Little Clinic in Kroger and Publix Stores;
 - Minute Clinic Health Care Centers in CVS Pharmacies and elsewhere;
 - Redi Clinic;
 - Take Care Clinic;
 - CVS MinuteClinic inside Target;
 - Wal-Mart Care Clinic;
 - CMG CareToday Clinics.

These clinics generally offer extended hours of operation (open 24 hours) and do not require appointments. They generally see patients within one-half hour or less. They offer limited services

in the treatment of minor illness or injury, and the services are performed by nurse practitioners under the direction of a staff physician—all for a primary care copay of \$25.

- The Cigna network of behavioral health providers includes psychiatrists, psychologists, certified psychological counselors, and other appropriate professionals. You may select any In-Network provider with the appropriate credentials for treatment.
- The CVS Caremark network of pharmacies includes all the retail pharmacies with which CVS Caremark has a contract. If the CVS Caremark logo is displayed, the retail pharmacy is available to you. CVS Caremark offers MILA participants mail order services exclusively through the CVS Caremark mail order system. As an alternative, CVS Caremark offers the Maintenance Choice program which enables mail order prescriptions up to 90 days to be filled at CVS retail pharmacies.

Although you are responsible for complying with the Plan's medical management procedures, In-Network providers generally are familiar with these procedures and will assist you in this process.

The In-Network providers have been selected based upon those providers' credentials and the quality of service which those providers have delivered in the past. Quality service always creates a more satisfactory experience for you and generally will result in a lower cost to the Plan.



Out-Of-Network Services — Not Covered

Out-of-Network medical and behavioral health services are not covered in the Basic plan. You must receive service from an In-Network provider in order for that service to be covered under the Plan. However, treatment rendered as a result of an emergency as defined on page 33 is paid in a manner similar to an In-Network service regardless of where it is rendered.

If you use an Out-of-Network pharmacy, you may incur additional expenses because MILA will reimburse you for no more than it would have paid the highly discounted In-Network pharmacies for each drug. See page 39 for more information.

In-Network Plan Benefits

In-Network benefits are subject to a copay when you visit a physician for service. The copay amounts are as follows:

- \$25 for a Primary Care Physician (PCP) or an in-store health clinic;
- \$40 when you visit a Specialist;
- \$15 for Psychological Counseling; and
- \$50 for Hospital Emergency Room visits, but this copay will be waived if the individual is admitted.

Other medical treatment is subject to a \$400 deductible (but no more than \$700 per family) during the calendar year. Thereafter, such expenses will be coinsured with you paying 30% of the cost. Except for counseling visits, behavioral health services are coinsured with you paying 30% of the cost.

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 or if any other family member is hospitalized, a second \$350 copay will not apply for that year.

Visits to the emergency room of an In-Network hospital for routine (non-emergency) medical treatment are not covered.

Prescription Drug Benefits

Prescription drugs are subject to the copay applicable to the type of drug indicated in the Basic Plan Benefits Summary. If you have a prescription for a brand drug for which there is a generic equivalent drug, the generic drug will be issued, unless the prescribing physician has indicated that substitution may not occur. In that case, the cost of the prescription may be subject to the \$500 deductible per family each calendar year. See page 38 for more information on the prescription drug deductible and generic drug substitution.

If your physician prescribes a Specialty medication, you must fill that prescription through the CVS Caremark Specialty Pharmacy in order for that prescription to be covered under the MILA Plan. See pages 42–43 for more information on this program.

If you use an Out-of-Network pharmacy, you may incur additional expenses because MILA will reimburse you for no more than it would have paid the highly discounted In-Network pharmacies for each drug. See page 39 for more information.

If you are covered by another prescription drug program in addition to the MILA Plan, notify MILA of your other coverage so your benefits can be coordinated to provide you with the best coverage. See page 43 for more information.

Out-Of-Pocket Expense Maximum

Your total out-of-pocket expense for deductible and coinsurance payments for medical and behavioral health services and supplies is limited to no more than \$5,000 per individual each calendar year. The limit does not include medical or behavioral health copay expenses or prescription drug deductible or copay expenses.

MILA Core Plan

Benefits Summary

Shown below is the MILA Core Plan Benefits Summary for eligible active Members. This chart allows you to see at a glance the key plan features. The copay, deductible, and coinsurance amounts below reflect what you pay. MILA pays the balance of covered charges.

Summary Of The MILA National Health Plan: Core Benefits		
	Core Plan	
Features	In-Network	
Calendar Year Deductible —This deductible applies to both medical and behavioral health benefits.		
Individual	\$750	
Family Limit	\$1,500	
Annual Out-of-Pocket Maximum — This maximum includes your deductible and coinsurance payment for medical and behavioral health benefits.		
Individual	\$7,500	
Family Limit	\$15,000	
No Lifetime Maximum Benefit		
Physician Services Copay/Visit		
Primary Care Physician (PCP)	\$35 copay/visit	
Specialist Physician	\$50 copay/visit	
Behavioral Health Provider	\$35 copay/visit	
Preventive Care	\$35 copay/visit	
Maternity Care (one/pregnancy)	\$35 copay/visit	
Hospital Care		
Hospital Inpatient Care including professional services (Precertification Required)	\$500 copay/40% of the network charge after deductible	
Hospital Outpatient Care including professional services	40% of the network charge after deductible	
Emergency Room (emergency only/waived if admitted)	\$75 copay/visit	
Urgent Care Center	\$50 copay/visit	
Ambulance	40% of the network charge after deductible	
Skilled Nursing (up to 100 days per calendar year)	40% of the network charge after deductible	
Home Health Care—(Includes up to 120 visits per calendar year.) Visits include part-time or intermittent nursing care or for care supervised by an RN, part-time or intermittent services of a home health aide and visits for physical, occupational or speech therapy.	40% of the network charge after deductible	
Prescription Drug		
Prescription Brand Deductible per Individual	In-Network	Out-Of-Network
	\$500 Deductible applies to all Brand Name Drugs	
Retail		
Retail Copay—30-day supply (Generic)	\$10	\$10
Retail Copay—30-day supply (Preferred Brand)	\$20	\$20
Retail Copay—30-day supply (Non-Preferred Brand)	\$50	\$50
For Retail: Up to 30-day supply—First fill plus one refill per prescription		
Maintenance Choice or Mail Order		
Mail Order Copay—90-day supply (Generic)	\$20	NOT COVERED
Mail Order Copay—90-day supply (Preferred Brand)	\$50	
Mail Order Copay—90-day supply (Non-Preferred Brand)	\$125	
For Mail Order & Maintenance Choice: Up to 90-day supply		

In-Network Services

Each Claims Administrator has a provider network for the use of Plan Participants.

- The Cigna network is a broad based preferred provider network from which you may select any participating physician, hospital or other provider if that provider has been contracted for the service. For example, you might select a cardiologist to treat heart ailments.
- The Cigna network includes in-store health clinics in select locations under the brand names of:
 - Little Clinic in Kroger and Publix Stores;
 - Minute Clinic Health Care Centers in CVS Pharmacies and elsewhere;
 - Redi Clinic;
 - Take Care Clinic;
 - CVS MinuteClinic inside Target;
 - Wal-Mart Care Clinic;
 - CMG CareToday Clinics.

These clinics generally offer extended hours of operation (open 24 hours) and do not require appointments. They generally see patients within one-half hour or less. They offer limited services in the treatment of minor illness or injury, and the services are performed by nurse practitioners under the direction of a staff physician—all for a primary care copay of \$35.

- The Cigna network of behavioral health providers includes psychiatrists, psychologists, certified psychological counselors and other appropriate professionals. You may select any In-Network provider with the appropriate credentials for treatment.
- The CVS Caremark network of pharmacies includes all the retail pharmacies with which CVS Caremark has a contract. If the CVS Caremark logo is displayed, the retail pharmacy is available to you. CVS Caremark offers MILA participants mail order services exclusively through the CVS Caremark mail order system. As an alternative, CVS Caremark offers the Maintenance Choice program which enables mail order prescriptions up to 90 days to be filled at CVS retail pharmacies.

Although you are responsible for complying with the Plan's medical management procedures, In-Network providers gen-

erally are familiar with these procedures and will assist you in this process.

The In-Network providers have been selected based upon those provider credentials and the quality of service which those providers have delivered in the past. Quality service always creates a more satisfactory experience for you and generally will result in a lower cost to the Plan.

Out-Of-Network Service— Not Covered

Out-of-Network service is not covered in the Core Plan. You must receive service from an In-Network provider in order for that service to be covered under the Plan. However, treatment rendered as a result of an emergency as defined on page 33 is paid in a manner similar to an In-Network service regardless of where it is rendered.

In-Network Plan Benefits

In-Network benefits are subject to a copay when you visit a physician for service. The copay amounts are as follows:

- \$35 for a Primary Care Physician (PCP) or an in-store health clinic;
- \$50 when you visit a Specialist;
- \$35 for Psychological Counseling for a PCP;
- \$50 for a Specialist visit; and
- \$75 for Hospital Emergency Room visits, but this copay will be waived if you are admitted.

Other medical treatment is subject to a \$750 deductible (but no more than \$1,500 per family) during the calendar year. Thereafter, such expenses will be coinsured with you paying 40% of the cost.

Except for counseling visits, behavioral health services are coinsured with you paying 40% of the cost.

When you are hospitalized at an In-Network hospital you will pay a copay of \$500 and then 40% of the remaining cost. Visits to the emergency room of an In-Network hospital for routine (non-emergency) medical treatment are not covered (see page 33 for definition of an emergency).

Prescription Drug Benefits

Prescription drugs are subject to the copay which is applicable to the type of drug indicated in the Core Plan Benefits Summary. All brand drugs are first subject to the \$500 deductible per individual each calendar year. If you have a prescription for a brand drug for which there is a generic equivalent drug, the generic will be issued, unless the prescribing physician has indicated that substitution may not occur. See page 38 for more information on the prescription drug deductible and generic drug substitution.

If your physician prescribes a Specialty medication, you must fill that prescription through the CVS Caremark Specialty Pharmacy in order for that prescription to be covered under the MILA Plan. See pages 42–43 for more information on this program.

If you use an Out-of-Network pharmacy, you may incur additional expenses because MILA will reimburse you for no more than it would have paid the highly discounted In-Network pharmacies for each drug. See page 39 for more information.

If you are covered by another prescription drug program in addition to the MILA Plan, notify MILA of your other coverage so your benefits can be coordinated to provide you with the best coverage. See page 43 for more information.

Out-Of-Pocket Expense Maximum

Your total out-of-pocket expense for deductible and coinsurance payments for medical and behavioral health services and supplies is limited to no more than \$7,500 per individual and no more than \$15,000 per family in covered expenses each calendar year. The limit does not include medical or behavioral health copay expenses or prescription drug deductible or copay expenses.



MILA Medicare Wrap-Around Plan

Benefits Summary

Shown below is the MILA Medicare Wrap-Around Plan Benefits Summary for Pensioners who are eligible to enroll for Medicare. This chart allows you to see at a glance the key plan features. Medicare pays its benefits first. Then, with respect to the balance of eligible expenses indicated in your Medicare Explanation of Benefits (Medicare EOB), you pay the deductible and the coinsurance amounts shown in this chart. MILA then pays the balance of covered charges on the basis of the MILA Medicare Wrap-Around Plan.

Summary Of The MILA Medicare Wrap-Around Plan		
Who Is Eligible For Coverage	Regular Pensioners and their dependents who are eligible to enroll in Medicare and who are not enrolled in a Medicare Advantage Plan.	
If eligible, must a person enroll in Medicare?	The covered person must enroll in Medicare, Part A and Part B. Generally, the person should not enroll in Medicare, Part D.	
Which Plan pays first and controls—Medicare or MILA?	Medicare pays before MILA. If the expense is eligible for Medicare benefits, Medicare's rules apply. Otherwise, MILA's rules apply.	
What expenses are eligible for MILA reimbursement?	Generally, the Plan pays benefits based upon the person's Medicare deductibles and coinsurance expenses that remain after Medicare's payments.	
What Benefits Will MILA Pay		
For Medicare, PART A	MILA will pay 100% of the Part A deductible and the portion of any expense which is covered by Medicare but is the Member's responsibility.	
For Medicare, PART B	Your annual deductible under MILA will match the Medicare Part B Annual Deductible that is set by the Centers for Medicare & Medicaid Services each year. Please refer to the Medicare and You handbook which is mailed by Medicare to all Medicare households each fall for the annual deductible or visit Medicare.gov or call 1-800-MEDICARE to get specific cost information.	
Skilled Nursing (up to 100 days per calendar year)	Person pays 20% of Eligible Charge after deductible	
Home Health Care—(Includes up to 120 visits per calendar year.) Visits include part-time or intermittent nursing care or for care supervised by an RN, part-time or intermittent services of a home health aide and visits for physical, occupation or speech therapy.	Person pays 20% of Eligible Charge after deductible	
What Is The Person's Maximum Out-of-Pocket Expenses?	The person will pay no more than \$2,500 in MILA deductible and coinsurance expenses during the calendar year.	
What Is The Plan's Maximum Benefit?	The MILA Plan will pay no more than \$500,000 during a person's retirement.	
Plan Limitations and Exclusions.	The Premier Plan's provisions which apply to Out-of-Network benefits also apply to this Plan unless Medicare applies a benefit limit, in which case, the Medicare limit will apply.	
Prescription Drug	In-Network	Out-Of-Network
Prescription Brand Deductible per Individual	\$500 Deductible applies to all Brand Name Drugs when a generic equivalent is available.	
Retail		
Retail Copay—30-day supply (Generic)	\$5	\$5
Retail Copay—30-day supply (Preferred Brand)	\$10	\$10
Retail Copay—30-day supply (Non-Preferred Brand)	\$25	\$25
For Retail: Up to 30-day supply—First fill plus one refill per prescription		
Maintenance Choice or Mail Order		
Mail Order Copay—90-day supply (Generic)	\$5	NOT COVERED
Mail Order Copay—90-day supply (Preferred Brand)	\$15	
Mail Order Copay—90-day supply (Non-Preferred Brand)	\$50	
For Mail Order & Maintenance Choice: Up to 90-day supply		

IMPORTANT

The following is important information that every person covered under the MILA Medicare Wrap-Around plan should keep in mind when obtaining medical services or prescription drugs. This information will help you obtain the highest level of benefits from the Medicare Wrap-Around plan while ensuring that you obtain the care you require.

Introduction

The MILA Medicare Wrap-Around plan is designed to supplement the benefits provided by Medicare Parts A and B, for MILA Pensioners and their eligible dependents who are eligible to enroll in traditional Medicare and do so. It will not supplement the benefits provided by Medicare Part C (that is, Medicare Advantage Plans) or Medicare Part D (that is, Prescription Drug Plans). It is extremely important that each person who is eligible for MILA Medicare Wrap-Around plan benefits enroll in Medicare Parts A and B, and the individual enroll in a “timely manner” as defined by Medicare. This is because coverage under the MILA Medicare Wrap-Around plan is incomplete without Medicare coverage in both Parts A and B.

If you do not “timely enroll” in Medicare, you will be deemed a “late entrant” by Medicare and the Medicare Part B premium will be permanently increased. MILA Medicare Wrap-Around plan coverage will begin when entitlement to Medicare benefits could first have begun upon timely enrollment, not when it actually does begin for a “late entrant.”

During the period between the beginning of the MILA Medicare Wrap-Around plan coverage and entitlement to Medicare benefits, MILA will estimate the benefit that Medicare would have provided in both the discounted charges and the Medicare benefit payments, and the Plan will pay benefits as if Medicare had actually paid. You will be responsible for paying the provider for any lost discounts that Medicare would have been entitled to receive and for the additional costs that Medicare would have paid if you had timely enrolled.

Benefits payable by Medicare under both Parts A and B are a part of the deductible for this Plan. The same broad coverage that is available in the Premier, Basic and Core plans is provided in the MILA Medicare Wrap-Around plan.

However, because Medicare must pay its portion of the cost before MILA, Medicare’s discounts and medical management

procedures will be used instead of MILA’s Claims Administrator’s discounts and management procedures when Medicare covers the expense. If Medicare does not cover an expense which the Plan regards as eligible for coverage, then it will be covered subject to the deductible and coinsurance which is indicated in the MILA Medicare Wrap-Around Plan Benefits Summary. MILA’s normal discounts and management procedures will apply.

Medicare Options

Medicare offers two additional options for which you may enroll. They are:

- Medicare Advantage Plans that used to be called Medicare Part C Plans; and
- Medicare Part D Prescription Drug Plans.

If you are considering enrolling in either option, you should consider your choice carefully. Enrolling in either of these Medicare plans will completely replace benefits under the MILA Medicare Wrap-Around plan and could jeopardize your enrollment in the MILA Medicare Wrap-Around plan. See below and page 18 for further explanation.

Medicare Advantage Plans

If you enroll in a Medicare Advantage Plan, that coverage will completely replace your traditional Medicare Parts A and B and it will replace your MILA Medicare Wrap-Around plan coverage on the date the Medicare Advantage Plan coverage begins.

- If the Medicare Advantage Plan contains a Medicare Part D prescription drug benefit, MILA will reimburse you for the standard cost of the Medicare Part B premium. This is the premium you must pay unless your income has caused Medicare to charge you a higher premium. It does not contain “late entrant” penalty charges.
- If your Medicare Advantage Plan does not contain a Medicare Part D prescription drug benefit, you must separately enroll for a Medicare Part D Prescription Drug Plan (Medicare PDP). MILA will reimburse you for the standard cost of the Medicare Part B premium.
- To receive reimbursement of the Medicare Part B premium, you must supply MILA with proof of your enrollment in both the Medicare Advantage Plan and in a Medicare PDP. For example, you should supply MILA with a copy of the front and back of your Medicare Advantage Plan identification card and, if you are required to pay a premium to the Medicare Advantage Plan, also supply a copy of your premium statement for a current date.

- If you enroll in a Medicare Advantage Plan and subsequently decide to discontinue this coverage and return to traditional Medicare Parts A and B coverage, MILA will readmit you to MILA Medicare Wrap-Around plan coverage on the date your traditional Medicare coverage begins. You must supply MILA with proof of your reinstatement in traditional Medicare Parts A and B. You should be careful because Medicare limits the number of times that you may change back to traditional Medicare.

Medicare Part D Prescription Drug Plans

If you are covered in the MILA Medicare Wrap-Around plan and you or your Medicare eligible spouse also enroll in a Medicare Part D Prescription Drug Plan, your MILA Medicare Wrap-Around plan benefits will be reduced as follows:

- If you (the Member) enroll in a Medicare Part D Prescription Drug Plan, you will lose MILA prescription drug coverage for yourself and for each covered dependent, regardless of that person's Medicare status. Your medical and behavioral health coverage will remain in effect.
- If only your Medicare eligible spouse or one of your Medicare eligible dependents enrolls in a Medicare Part D Prescription Drug Plan, only that dependent will lose his or her MILA prescription drug coverage. That person's medical and behavioral health coverage will remain in effect.
- If you enroll in a Medicare Part D Prescription Drug Plan (and you have not enrolled in a Medicare Advantage Plan) and subsequently you end your Medicare Part D PDP enrollment for any reason, MILA will readmit you to prescription drug coverage under the MILA Medicare Wrap-Around plan on the date your Medicare Part D PDP coverage ends. You must supply MILA with proof of your disenrollment from the Medicare Part D PDP.

Medical Benefits Under Medicare

The Claims Administrator for your medical benefits will be Medicare, instead of Cigna, when Medicare covers the expense. The Claims Administrator for the Prescription Drug Program, CVS Caremark, supplies the network of retail and mail service pharmacies. It is important to keep in mind that the MILA Prescription Drug Program provides retail coverage on both an In-Network and an Out-of-Network basis at the benefit levels noted on the MILA Medicare Wrap-Around Plan Benefits Summary on page 16.

Since the Cigna network of providers is generally not available in the MILA Medicare Wrap-Around plan, your benefits will be similar to "Out-of-Area" benefits in the Premier Plan. The only time when In-Network benefits will be available to you is when you access the Member Assistance Plan (MAP) or when a service is not covered by Medicare, but it is covered by the Plan. This will happen very infrequently. See the explanation of the Out-of-Area benefits on page 9.

Most hospitals and other institutions are in the Medicare "network" under Part A., so MILA will pay the balance of the costs that you incur above what Medicare covers, as indicated in the MILA Medicare Wrap-Around Plan Benefits Summary.

Medicare covers physician's services under Part B. The Plan will supplement those payments, as indicated in the MILA Medicare Wrap-Around Plan Benefits Summary. Most physicians fall within one of three categories of physicians in the Medicare "network." While Medicare controls the prices that these physicians may charge, you choose the type of physician you use, which will determine your cost and MILA's cost.

- Physicians who "accept assignment" are physicians who will accept Medicare's payment as payment in full. When you use physicians who accept assignment, you and MILA will have no cost for their services after your Medicare Part B deductible has been satisfied for the calendar year.

For example, assume you have satisfied Medicare's deductible and you visit a physician who accepts assignment and bills \$200. If Medicare determines that \$100 is the covered charge, it will pay \$80 to the physician. That physician will accept this as "payment in full." Neither you nor MILA will have to pay the remaining \$20. Your Medicare Explanation of Benefits (EOB) will tell you this.

FOR EXAMPLE

Assume the same facts as above, except the physician participates in Medicare. Medicare would pay the same \$80 of the \$100 covered charge. Your Medicare EOB will tell you that you are responsible for the remaining \$20. Of this \$20, MILA will pay \$16 (80% of the \$20 balance). You will owe your physician \$4.

- Physicians who "participate in Medicare" accept Medicare's fee determination. Medicare will pay 80% of its allowable charge leaving 20% as the eligible charge for MILA to consider. After you have met the Medicare Plan

deductible, MILA will pay 80% of that balance (80% times 20% = 16%) leaving 4% for you to pay.

- Physicians who do not participate in Medicare are still subject to Medicare's price controls, but Medicare will reduce what it pays these physicians. Medicare allows them to charge you more, as shown in your Medicare Explanation of Benefits. In this situation, both MILA and you will pay more.
- There is a fourth category of physician called an "opt-out physician." This type of physician has signed a special agreement with Medicare that allows the physician to charge you whatever amount the physician wants. Medicare will not pay any amount to that physician. In order to do this, the physician must give you a separate contract that states that the physician has opted out of Medicare, that Medicare will not pay any portion of the physician's bill, and that you must pay all of the physician's billed charges. If you sign this type of agreement, MILA will pay the amount that it would have paid had the physician participated in Medicare and you will have to pay the entire balance of the physician's bill.

Whenever you visit a physician, you should ask that physician which of the four categories of physicians that physician is.

NOTE

When you are covered by Medicare, you may select any physician. Medicare does not require physicians to have credentials in order to participate in the Medicare network.

However, if you select a Cigna provider, you will know that the quality of this provider's medical practice has been reviewed and has been approved by Cigna.

Prescription Drug Benefits

Prescription drugs are subject to the copay that is applicable to the type of drug indicated in the MILA Medicare Wrap-Around Plan Benefits Summary. If you have a prescription for a brand drug for which there is a generic equivalent drug, the generic drug will be issued, unless the prescribing physician has indicated that substitution may not occur. In that case, the cost of the prescription will be subject to the \$500 deductible per family each calendar year. See page 38 for more information on the prescription drug deductible and generic drug substitution.

If your physician prescribes a Specialty medication, you must fill that prescription through the CVS Caremark Specialty Pharmacy in order for that prescription to be covered under the MILA Plan. See pages 42–43 for more information on this program.

If you use an Out-of-Network pharmacy, you may incur additional expenses because MILA will reimburse you for no more than it would have paid the highly discounted In-Network pharmacies for each drug. See page 39 for more information.

If you are covered by another prescription drug program in addition to the MILA Plan, notify MILA of your other coverage so your benefits can be coordinated to provide you with the best coverage. See page 43 for more information on this program.

The CVS Caremark network of pharmacies includes all the retail pharmacies with which CVS Caremark has a contract. For example, CVS Caremark has contracted with many Walgreen, Walmart and Rite Aid Pharmacies and many other drug stores. If the CVS Caremark logo is displayed, the retail pharmacy is available to MILA Members. CVS Caremark offers MILA participants mail order services exclusively through the CVS Caremark mail order system. As an alternative, CVS Caremark offers the Maintenance Choice program which enables mail order prescriptions up to 90 days to be filled only at CVS retail pharmacies.

Network Service

As is indicated in the MILA Medicare Wrap-Around Plan Benefits Summary, most benefits are available through Medicare doctors, under Medicare protocols, rather than Cigna protocols. There are some exceptions to this:

- First, prescription drugs are secured through CVS Caremark's network of retail and mail pharmacies, just as in the Premier, Basic and Core plans. The benefits are the same as in the Premier and Basic plans.
- Next, Member Assistance Plan (MAP) service is available to all Members in the Medicare Wrap-Around plan through Cigna.
- Finally, if a medical health service is not covered by Medicare but is covered under this Plan (that is, it would have been covered under the Premier Plan), then that service is covered. This will not happen often but, when it does, the service will be subject to the Plan's deductible and coinsurance as if it were an Out-of-Network expense in the MILA Out-of-Area Premier Plan.

Maximum Benefit

Under the MILA Medicare Wrap-Around plan, the maximum benefit payable will be \$500,000 per person during retirement. Benefits payable for a person during all periods of retirement will be aggregated.



MILA Dental Plan

Benefits Summary

Shown below is the MILA Dental Plan Benefits Summary for eligible active Members, and for those Pensioners age 58 and over who are eligible for benefits in the Premier, Basic, Core or Medicare Wrap-Around plans, Medicare Advantage Plans, and who have not waived participation in the MILA Dental Plan, as explained in Section IV, Participation. This chart allows you to see at a glance the key plan features. The deductible and coinsurance amounts are what you will pay when you seek treatment from a Participating Network Dentist. MILA pays the balance of covered charges up to the maximum benefit payable under the Plan. If you seek treatment from a dentist who does not participate in the Aetna Dental Network that is contracted for the MILA Dental Plan, you will be responsible for any additional charges made by that dentist beyond the negotiated rates that MILA has contracted to pay Participating Network Dentists.

Benefit Plan	For Members Participating In
Who Participates	
Active Members	Premier, Basic and Core Plans
Retired Members	Premier, Basic and Medicare Wrap-Around Plans
Retired Members	Medicare Advantage Plan if qualified for Medicare Part B premium reimbursement
Features	
Calendar Year Deductible Expenses	
Applies to the following expenses	Applies only to Basic and Major Expenses
Individual Deductible	\$25 per calendar year, waived for preventive
Family Deductible Limit	No more than \$75 per calendar year
Coinsurance Dental Expense Payable by Participant	
Preventive Dental Treatment	0% coinsurance (Plan pays 100%)
Basic Dental Treatment	15% coinsurance after deductible (Plan pays 85%)
Major Dental Treatment	15% coinsurance after deductible (Plan pays 85%)
Orthodontic Dental Treatment	15% coinsurance after deductible (Plan pays 85%)
Maximum Benefit Payable by Plan	
Payable for preventive, basic and major dental treatment incurred by each person during each calendar year	\$2,500 per person
Payable for orthodontic dental treatment incurred by a child during that child's lifetime	\$1,500 per person
Payable for orthodontic dental treatment incurred by an adult when medically necessary during that adult's lifetime	\$1,500 per person
Payable for dental implants incurred by each person when medically necessary during each calendar year	\$5,000 per person
Benefits payable Out-of-Network will be paid based on the amount that would have been paid had the treatment been performed by a Participating Network Dentist. Any additional amount charged by an Out-of-Network dentist will be your responsibility.	

IMPORTANT

The following is important information which every MILA Member covered under the MILA Dental Plan should keep in mind when accessing dental service. This information will help you obtain the highest level of benefits from the MILA Dental Plan while ensuring that you obtain the care you require.

In-Network Service

Aetna, MILA's Dental Claims Administrator, has contracted with certain dental providers for utilization by Plan Participants. The dental hygienists who operate under the supervision of the contracted dentists for certain specified services are also part of the network of dental providers.

- **The Network.** The Aetna Dental Network which has been contracted for the MILA Dental Plan is the "PPO/PDN with PPO II Network."
- **Discounted Fees.** Aetna Dental Network providers have agreed to charge MILA and you discounted service fees for the services covered in the MILA Dental Plan. If you obtain additional treatment that is not covered under the MILA Dental Plan from an In-Network dentist, that dentist may provide the Aetna discount on that other treatment if that dentist's contract with Aetna requires the dentist to do so. However, some dentists operate under contracts where they do not have to extend discounts to uncovered services. You should obtain a Pre-Treatment Estimate and discuss with your dentist the fees that will be charged before agreeing to any dental work that is not covered by the Plan.
- **Pre-Treatment Estimate.** If you need Basic or Major dental treatment that is expected to be extensive or to cost more than \$300, it is always a good idea to obtain a pre-treatment estimate of the cost of the dental treatment to be performed. The description of the dental treatment and its proposed charge will be completed by your dentist and sent to Aetna for review. Aetna will prepare an estimate of the charge for which you will be responsible and send it to your dentist. If the total charge for the work exceeds the amount payable by the Plan and/or your remaining annual maximum, you may want to discuss having your dentist do some of the work done over time in order to allow the Plan to cover more of the treatment. Also, if the Plan will cover only the cost of alternate treatment, you should discuss with your dentist whether that alternate treatment might achieve a satisfactory result.

Out-Of-Network Service

Occasionally, you may want to seek care from an Out-of-Network dentist. While the MILA Dental Plan provides coverage for Out-of-Network dental service, there are significant reasons why you generally should use In-Network providers.

- Dentists who participate in the network have been credentialed by Aetna and their services are regularly reviewed to ensure high quality and conformity with standards set by the American Dental Association.
- The MILA Dental Plan reimburses all dentists based on fees that have been negotiated with In-Network dentists and are substantially discounted over the fees regularly charged by other dentists in their geographic area and dental specialty of practice. Many Out-of-Network dentists will charge more than this negotiated fee.
- If you are treated by an Out-of-Network dentist not only will you pay the Plan deductible and coinsurance as a percentage of the negotiated fee; you will also be responsible for any charge made by the Out-of-Network dentist in excess of the In-Network charge.
- It is particularly important to secure pre-treatment estimates for work that will be performed by Out-of-Network dentists. This will allow you to understand what your costs will be before the work is done and will permit you to negotiate that cost with your dentist.
- In the case of a true dental emergency, the Plan will cover the necessary emergency service as if it were rendered In-Network regardless of whether the provider is an In-Network provider. See page 45 for additional information on the treatment of dental emergencies.

NOTE

You should attempt to use In-Network providers whenever possible in order to be assured of receiving the highest quality dental care at the lowest total cost.

MILA Vision Plan

Benefits Summary

Shown below is the MILA Vision Plan Benefits Summary for eligible active Members, and for those Pensioners age 58 and over who are eligible for benefits in the Premier, Basic, Core or Medicare Wrap-Around plans, Medicare Advantage Plans, and who have not waived participation in the MILA Vision Plan, as explained in Section IV, Participation. This chart allows you to see at a glance the key plan features. The copay amounts are what you will pay when you seek treatment from a Participating Network Vision Care Professional. MILA pays the balance of covered charges under the Plan. If you seek treatment from a vision care professional who does not participate in the EyeMed Vision Care Network that is contracted for the MILA Vision Plan, you will also be responsible for any additional charges made by that vision care professional beyond the negotiated rates that MILA has contracted to pay.

Vision Service	Member Cost	Out-Of-Network Allowance
Exam w/ Dilation	\$10 copay	\$30
Contact Lens Fit & Follow-up		
Standard Contact Lens	\$0 copay	\$40
Premium Contact Lens	90% retail cost less \$40	\$40
Frames		
Any available frame at provider location	\$15 copay, \$130 allowance, then 20% discount	\$40
Standard Plastic Lenses		
Single Vision	\$10 copay	\$25
Bifocal		\$45
Trifocal		\$80
Lenticular		\$80
Standard Progressive Lens		\$110
Premium Progressive Lens		See Price List
Lens Options		
UV Treatment	\$15	\$0
Tint (solid & gradient)		\$15
Standard Plastic Scratch Coating		\$15
Standard Polycarbonate—Adults	\$0	\$40
Standard Polycarbonate—Child <19		\$40
Standard Anti-Reflective Coating	\$45	\$0
Polarized	20% off retail	
Photocromatic/Transitions Plastic	\$75	
Premium Anti-Reflective Coating	See Price List	
Other Add-ons	20% off retail	
Contact Lenses (materials only)		
Conventional	\$10 copay, \$100 allowance, then 15% discount	\$75
Disposable	\$10 copay, \$100 allowance, then balance	\$90
Medically Necessary (see note on next page)	\$0 copay, \$500 allowance, then balance	\$475
Laser Vision Correction		
Lasik or PRK from US Laser Network	15% off retail or 5% off promotional	\$0
Additional Pairs Benefit after Plan benefit has been used	Members receive 40% discount off complete pair of eyeglasses and 15% discount off conventional contacts	
Frequency Limits		
Examination	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 24 months	

Note: Contact lenses will be considered “medically necessary” under the Plan only when one of the following conditions exists: (1) Anisometropia of 3D in meridian powers; (2) High Ametropia exceeding -10D or +10D in meridian powers; (3) Keratoconus when your vision cannot be corrected to 20/25 in either or both eyes using standard spectacle lenses; and (4) Vision improvement other than Keratoconus if your vision can be corrected two lines of improvement on the visual acuity chart when compared with best corrected standard spectacle lenses. The Vision Plan benefit may not be expanded for other eye conditions, even if you or your provider deems contact lenses necessary for other eye conditions or for visual improvement. However, this limitation in the Vision portion of the Plan coverage does not preclude consideration of your condition under the Medical portion of the Plan.

Price List	
Member Cost for Premium Progressive Lenses	
Tier I	\$30 copay
Tier II	\$40 copay
Tier III	\$55 copay
Tier IV	\$10 copay plus 80% of charge less \$120
Member Cost for Premium Anti-Reflective Coating	
Tier I	\$57 copay
Tier II	\$68 copay
Tier III	\$68 copay
Tier IV	80% of charge

You can review the list of Premium Progressive lens brands and premium Anti-Reflective Coating brands to determine the Tier of coverage at www.eyemed.com or call Customer Service at 1-866-939-3633.

Other Vision Plan Benefits

In addition to the specific benefits listed in the Vision Plan Benefits Summary and the Price List above, the following benefits are available:

- 20% discount on items not covered by the Plan, as listed above, when provided by In-Network providers. This discount may not be combined with any other discounts or promotional offers. The discount does not apply to the EyeMed Provider’s professional services or to contact lenses.
- 15% off the retail or 5% off the promotional price for Lasik or PRK from the US Laser Network, which is owned and operated by LCA Vision.
- You can now apply your in-network contact lens benefit at contactsdirect.com. Simply complete the online transaction form and the contacts will be delivered directly to your home.
- The benefit allowances specified are applied “per use” and any excess will not be carried forward for subsequent purchases during the same benefit period.
- Certain brand name vision materials cannot be discounted because of “no discount” agreements made with the manufacturers.
- Discounts may not be available at all participating providers. Please see EyeMed’s online provider locator to determine which participating providers have agreed to the discounted rates.
- Pursuant to Maryland and Texas law, discounts on non-covered services may not be available at all participating providers in these states. Prior to your appointment, please confirm with your provider whether such discounts will be offered.

Understanding What Is Covered

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What Is Covered

As you read the following pages, you'll see that the MILA National Health Plan considers most hospital, surgical and medical services to be covered expenses. But your expenses will be covered only when they are for "medically necessary care." Also note that if you go Out-of-Network, your eligible expenses are reimbursed only up to what the Claims Administrator determines is the "reasonable and customary" charge for that particular service or supply. In contrast, In-Network charges are always considered "reasonable and customary." It's also important to understand that certain procedures require advance approval to be eligible for reimbursement. Each of these important Plan provisions is described in this section.

The Medical Plan

Medically Necessary Care

The Medical Plan covers only those expenses the Claims Administrator determines to be medically necessary.

Medically necessary services are services that are reasonable and necessary to diagnose and treat an illness or injury at the appropriate level of care.

Medically necessary covered services are those services and supplies that are determined to satisfy all of the following criteria:

- Delivered in a quantity that is no more than is required to meet your basic health needs;
- Consistent with the diagnosis of the condition for which they are required;
- Required for purposes of the medical treatment and not for the comfort or convenience of the patient or physician;

- Rendered in the least intensive setting that is appropriate for the delivery of the required health care; and
- Of demonstrated medical value.

The evaluation of whether medical treatment is medically necessary is applied to the entire episode of care and not to the separate segments of care. An episode of care is the period beginning with the first interaction of the medical provider and the patient. It continues during the treatment of the illness or injury and ends with any support that the Claims Administrator's contracted agencies provide to assist the patient in returning to normal activities of daily life in which further medical intervention is not required.

In all circumstances, the Claims Administrator will condition coverage on its determination that the treatment meets the specific Plan requirements and has full discretionary authority to rely on its own materials, expertise and procedures.

Discretionary Authority Of Plan Administrator And Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each benefit program of the Plan, have full discretionary authority to (1) interpret the terms of the Plan, to resolve ambiguities, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan and (2) make all factual determinations arising under the Plan and in connection with any claims for benefits thereunder, and applying the facts to the terms of the Plan.

Any review of a final decision or action of the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each benefit program of the Plan shall be based only on such evidence presented to or considered by them at the time they made the decision that is the subject of review. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Experimental Or Investigational Treatment Or Care

Experimental or investigational treatment or care will not be considered medically necessary care under this Plan. The terms "experimental or investigational" mean services, supplies, care and treatment which do not constitute an accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a

reasonably substantial, qualified, responsible, relevant segment of the medical or dental community or government oversight agencies at the time services were rendered.

The Claims Administrator must make an independent evaluation of specific technologies to determine whether they are experimental. The Claims Administrator shall be guided by a reasonable interpretation of the Plan provisions. The Claims Administrator's decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Claims Administrator will be final and binding on the Plan.

In addition, drugs will be considered experimental or investigational if they are not commercially available for purchase and/or they are not approved by the United States Food and Drug Administration (FDA) for general use. The Claims Administrator will consider the following as indications that the drug, device or treatment is experimental or investigational:

- If the drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given by the FDA at the time the drug or device is furnished; or
- If the device has been granted a Category A experimental/investigational device exemption by the FDA; or
- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, medical treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
- If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is in the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reasonable And Customary Charges

When care is rendered In-Network, the charges are always considered reasonable and customary by the Plan. This is true because the Claims Administrator has negotiated the charges which will be rendered to the Plan by the providers. The network providers have agreed that the only charges which may be rendered to the Members are those specifically provided by the Plan. Your portion of those charges would include the deductible, the copay or the specific percentage of the negotiated fee specified in the Plan.

When you go to an Out-of-Network provider, you are responsible for any amounts which exceed the reasonable and customary charge for a covered service or supply.

The reasonable and customary charge is the lower of the provider's usual charge or what the Claims Administrator determines is the prevailing charge in the geographic area where this service or supply is furnished.

In determining the reasonable and customary charge for a service or supply that is unusual, not often provided in the area or provided by only a small number of providers in the area, the Claims Administrator may take into account factors such as:

- The complexity of the service;
- The degree of skill needed;
- The provider's specialty; and
- The range of services or supplies provided by a facility and the prevailing charge in other areas.

Cigna and Cigna Behavioral Health determine the reasonable and customary charge for Out-of-Network charges from a large database of actual charges that have been submitted by many carriers and adjusted periodically (usually, every six months) to add current data and to remove statistically aberrant examples. In contrast, Aetna, CVS Caremark and EyeMed determine the reasonable and customary charge for Out-of-Network charges from the charge each vendor is contracted to pay its network provider for the same service or supply.

Approving Your Care

Care coordination is a "checks and balances" program for your medical care. To help make sure you get the right kind of treatment, at the right time, a care coordinator reviews your condition before, during and after you receive your medical care.

You should discuss any non-emergency surgery or institutional admission (e.g., hospital, skilled nursing facility, etc.) or advanced radiological treatment or service with a Cigna care

coordinator prior to the procedure being performed or prior to admission. This will ensure that you and your physician understand the coverage your MILA Plan will provide and what your costs for the procedure will be.

Hospital admissions always require approval for maximum benefits to be paid. If your admission is planned, approval is required in advance. Emergency admissions require approval within 48 hours after the admission. A maternity admission requires approval only if the stay exceeds 48 hours (96 hours for a cesarean section).

Hospital admissions will be approved for a specific number of days. If your stay must be extended for some reason beyond the approved number of days, you or your representative must call the Cigna care coordinator to obtain approval for the additional days. The care coordinator will certify those days that are approved under the Plan.

In addition, certain procedures, treatments and supplies — whether from an In-Network provider or another provider — must be approved before you receive them in order for the Plan to pay the maximum benefit.

The following surgeries and procedures require advance approval, regardless of whether they are performed on an inpatient or an outpatient basis. This list includes but is not limited to:

- Adenoidectomy;
- Carpal tunnel release;
- Cataract extraction;
- Cholecystectomy;
- Colonoscopy;
- Coronary angiography;
- Hernia repair;
- Hysterectomy;
- Hysteroscopy;
- Knee arthroscopy;
- Lumbar myelography;
- Magnetic resonance imaging (MRI)—brain, cervical, lumbar, musculoskeletal, thoracic regions;
- Myringotomy with tube insertion;

- Pelvic laparoscopy;
- Positron-emission tomography (PET) scan;
- Sinus surgery (all);
- Surgical procedures of the shoulder (including arthroscopy);
- Tonsillectomy; and
- Upper gastrointestinal (UGI) endoscopy.

Advance approval is also required if your doctor orders any of the following special care or services. This list includes but is not limited to:

- Care in a skilled nursing facility;
- Home health care;
- Hospice care; and
- Transplant surgery.

NOTE

If you use an In-Network provider, that provider will call the Cigna care coordinator directly for approval. However, it is your responsibility to verify that your provider has taken care of this for you.

If you use an Out-of-Network provider, it is your responsibility to call for approval. Either you or someone who can speak for you must call the care coordinator. See the MILA Resources chart at the back of this SPD, in the Administrative Information section, for how to find a Cigna care coordinator.

Approval must be requested at least four business days (Monday through Friday) before you have a procedure performed. Different rules apply to medical emergencies; see [here](#) for more information.

If You Do Not Get Approval

If your procedure, treatment or service requires approval and you do not contact a care coordinator before treatment begins, your benefits may be reduced.

The Plan will reduce your normal reimbursement by 20% of the amount of the eligible charge if:

- You do not call for approval at least four business days before being hospitalized (or for a valid emergency, within

48 hours following admission) or for any extension of the originally approved length of stay before such extension begins; and

- You do not call for approval before receiving one of the procedures where approval is required.

If you call for approval, but the care you request is reviewed by the care coordinator and found not to be medically necessary, the care will not be covered.

Any additional expenses you have to pay because you did not get proper approval do not count toward your deductible, annual out-of-pocket maximum or the Plan's coordination-of-benefits provision.

Approval If You Have Other Coverage

If you or a covered dependent are in another benefit plan and the MILA National Health Plan is the patient's secondary coverage, approval works as follows:

- If the other plan requires continued stay review and/ or advance approval — just as the MILA National Health Plan does — then the other plan's approval satisfies the MILA National Health Plan's requirement for approval. You do not need additional approval from the MILA National Health Plan.
- If the other plan does not require a review or advance approval and MILA does, you must obtain advance approval from a MILA National Health Plan care coordinator to qualify for maximum benefit coverage.
- If Medicare is your primary plan and it covers the procedure, no prior approval is required from the MILA National Health Plan.

For additional information about how benefits are coordinated when you are covered by another benefit plan, see page 60.

Finding An In-Network Provider

The most reliable way to find out if a doctor, specialist or other medical provider is in the Cigna Open Access network, is to simply ask him or her. You can also:

- Call the toll-free numbers on your MILA/Cigna ID card;
- Use the smart phone app available from www.myCigna.com; or
- Go online to Cigna at www.Cigna.com, or to MILA at www.milamhctf.com.

The contact numbers are also located on the MILA Resources chart in the Administrative Information section, in the back of this SPD. Be sure to double-check with any provider you find to be certain that he or she is still participating in the Network.

If you have access to a computer and the Internet, you can visit the Cigna Health Center website at www.Cigna.com to:

- Find a current listing of In-Network physicians, specialists and other medical providers;
- See frequently-asked questions and answers about health issues;
- Find a glossary that explains many medical terms;
- Contact Cigna's own customer service representatives for additional information;
- Find useful health information including the details on Cigna and other services; and/or
- Check a special secure, password-protected website at www.myCigna.com where, once you log on, you can access personalized health and benefit information and decision support tools. (For example, you can check the status of claims, find answers to frequently-asked questions, order an ID card, and much more.)

Your Medical Or Prescription Drug ID Card

Unless you are injured at work or in an automobile accident, you should present your MILA/Cigna ID card each time you visit a doctor or other medical provider, or when you go to the hospital. Your MILA/Cigna ID card shows the Plan name and the group number, as well as Cigna's toll-free numbers for Member Services. You should keep this card with you at all times.

NOTE

Members can download a free, personalized smart phone app for Android and iOS devices. You can do almost anything on the go—getting medical ID cards, checking account balances, reviewing medical claims and locating doctors and hospitals. The information is presented in real time, offering Members the most accurate, up-to-date account information. Go to www.myCigna.com to find instructions on how to download the application that fits your mobile device or tablet.

You should present your MILA/CVS Caremark ID card at the pharmacy each time you want to fill or refill a prescription. If you do not show the pharmacist your MILA/CVS Caremark ID card, then you cannot properly process your prescription as a network expense and your prescription may be processed as Out-of-Network.

If you lose or damage your ID card, call MILA immediately to request a replacement. If you have an emergency and don't have your card with you, either have a family member or friend bring it to the emergency room as soon as possible or call MILA.

Covered Medical Services

This section describes expenses that are eligible for reimbursement under the MILA National Health Plan. How these expenses are reimbursed depends on whether you use In-Network or Out-of-Network providers.

Routine Preventive Care (In-Network Only)

The Plan covers preventive care only when it is provided by an In-Network doctor (unless you are eligible for Premier plan Out-of-Area benefits or the MILA Medicare Wrap-Around plan). Covered routine preventive care refers to regular check-ups that are generally recommended on a fixed schedule and performed by a primary care physician (PCP). A PCP can be a family or general practitioner, an internist, pediatrician or gynecologist. Visits to your PCP for routine preventive care require no advance approval and include the following services when provided by the PCP during the visit:

- Annual physical exams;
- Annual gynecological exams or initial maternity visits;
- Annual Pap smears;
- Mammograms;
- Newborn/well baby care to age three—routine exams and immunizations;
- Children age three or older—annual exam and immunizations; and
- Hearing exams—one every two years.

Lifestyle Management Programs

The Plan provides three optional programs which are available to all Members who participate in the Premier, Basic or Core

plans. The Trustees encourage you to review the features of the programs with your physician and to participate in those that you and your physician believe would be beneficial.

Weight Management Program: The Cigna Weight Management Program offers assistance to “at risk” Members as identified through the results of an HRA (Health Risk Assessment) questionnaire and/or self-enrollment. Members may also be referred to this program by their physicians. Wellness Coaches will use education, coaching techniques, and action planning, along with referral to Plan-based programs.

Tobacco Cessation: The Cigna Tobacco Cessation Program educates and supports Members in their tobacco cessation efforts. Participants in the telephone program receive print materials, individual coaching calls with a dedicated wellness coach, and access to optional group coaching calls. Coaching strategies are based upon behavioral modification, motivational interviewing, and stages of change intervention techniques. Participants in the web-based program receive convenient online registration; a two-week “planning to quit” and six-week “quit for good” module; e-mails with articles of interest, online tools to use, and ways to track progress; a request form for nicotine replacement therapy; and the ability to contact a web coach via telephone.

Stress Management: The Cigna Stress Management Program offers participants practical solutions for improving management of stress. The program helps participants to: (1) identify their personal stress response, (2) reduce stress at work, (3) develop strategies for improving work/life balance, (4) improve physical activity/nutrition/sleep, (5) increase their physical resilience to stress, (6) improve their time management, and (7) learn relaxation techniques and coping strategies.

Disease Management Program For Chronic Conditions

MILA offers disease management programs to assist persons with the following diseases to better manage their conditions. Cigna calls its program the “Your Health First” program or the YHF program. Although Cigna may add or delete a disease from the YHF program, the current diseases on which the program is focused are as follows:

- Asthma;
- Chronic Obstructive Pulmonary Disorder or COPD (emphysema and chronic bronchitis);
- Low back pain;
- Metabolic Syndrome;
- Osteoarthritis;

- Diabetes mellitus—Type 1;
- Diabetes mellitus—Type 2;
- Peripheral artery disease;
- Cardiac concerns:
 - Acute myocardial infarction;
 - Angina;
 - Congestive heart failure;
 - Coronary artery disease;
 - Heart disease;
- Behavioral concerns:
 - Anxiety;
 - Bipolar disorder; and
 - Depression.

Cigna’s clinicians have selected these conditions based on individual’s and physician’s ability to modify the direction of illness, change lifestyles and behaviors, and reduce medical costs. Your Health First (YHF) incorporates the whole person focusing on all aspects of a Member’s health and well-being. It provides participants with resources, tools and primary health advocate support to help patients manage their conditions and improve lifestyles. Cigna’s program offers two unique advantages:

- A complete picture of a person’s health is reviewed, weaving together behavioral, lifestyle, social and physical

factors to create one dynamic, integrated, custom-fit advocacy plan.

- The severity of a person’s condition and their willingness to change is measured.

Cigna works with the individual to create a plan that helps each person successfully reach their health goals. Active coaching, self-guided support, and cutting-edge technology are all employed to maximize outreach and outcomes for the program.

The YHF program is completely voluntary for persons covered in the Premier, Basic or Core plans who have one or more of the targeted conditions. If Cigna detects that you have one of these conditions, a representative of the program may invite you to participate. If you have not received an invitation or did not choose to participate when initially asked but would like to give it a try, let MILA know.

The YHF program is managed for each person based upon their unique conditions and needs. After your management program has been set up with advice from and consultation with your doctors, a nurse will call you at regularly scheduled intervals to help implement your program. The nurse will supply a variety of disease appropriate tools to assist you and your physician in managing your conditions.

Case Management For Catastrophic Conditions

If you require extensive medical treatment for a catastrophic illness or injury, the Claims Administrator may offer case management services to assist you and your physician in developing a treatment plan for your condition and in arranging the services necessary to effectively implement that treatment



plan. If you and your physician agree to accept this assistance, all services rendered under the treatment plan will be treated as In-Network services, even if some of the services would ordinarily have been Out-of-Network.

Maternity Care

Benefits for maternity care are available only to you or your spouse. Charges related to the pregnancy of a dependent child are not covered.

All care of the mother and the unborn child before the birth is treated just like any other medical care covered by the Plan. In addition, under federal law, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. If a longer stay is medically necessary, a care coordinator must approve the needed extension of time.

Care and services that diagnose or treat the condition of a fetus before birth are not covered (unless medically necessary). Such treatments include but are not limited to:

- Amniocentesis and/or chromosomal analysis;
- Fetal monitoring;
- Pregnancy-related ultrasounds;
- Alpha fetoprotein; and
- Chorionic villus biopsy.

Family Planning

Family Planning services are covered only if you go to In-Network providers (or to any qualified provider if you are eligible for Out-of-Area benefits). Covered services include:

- Information and counseling on contraception;
- Physical examination, related lab tests, medical history and other medical services related to voluntary family planning that are generally accepted medical practices;
- Oral contraceptives and the specific products NuvaRing and Ortho Evra (note that these products are covered only under the prescription medication portion of the Plan);
- Intrauterine devices (IUD) will be covered in-network only at 100%;
- Vasectomy, tubal ligation and other surgical therapies for pregnancy prevention, and the medical counseling that ensures you understand the effect of these procedures.

The cost of services or surgery to reverse these procedures is not covered;

- Infertility treatments performed by an In-Network Provider are covered for active employees, pensioners and their spouses age 21 through 44 with a maximum lifetime benefit of \$40,000; \$30,000 of that maximum will apply to covered medical services and \$10,000 of that maximum will apply to medication;
- Male sexual dysfunction treatment that is medically necessary (including penile pump and penile implant surgery) is covered with a maximum lifetime benefit of \$20,000. In the MILA Medicare Wrap-Around plan, Medicare will perform the medical necessity review, MILA/Cigna pays secondary to Medicare. **The combined Medicare and MILA benefit cannot exceed \$20,000.** Medicare will be your provider for this benefit;
- Hearing aids (maximum benefit of \$1,500 per ear once every three years only through a provider designated by the Claims Administrator; and
- Services and supplies from In-Network providers related to gender dysphoria including, but not limited to, medically necessary services and supplies for counseling, surgery, durable equipment and prescription drugs.

Care From A Specialist

A specialist is a provider whose practice is limited to a specific disease (for example, an oncologist), specific parts of the body (podiatrist), a specific age group (pediatrician) or a specific procedure (oral surgeon). Some specialists may also provide the general medical services of a PCP. You do not need a referral to visit a specialist. However, the specialist may decide you need a procedure or treatment that requires advance approval. See page 28 for a list of procedures and treatments that require prior approval. Types of specialty care that are covered under the Plan include:

- Care provided by any medical specialist including a cardiologist, a pulmonologist, a gastroenterologist, a neurologist, a rheumatologist and so forth;
- Podiatry, for the treatment of corns, calluses, weak or flat feet, fallen arches, chronic foot strain or instability of the feet, toenails (including removal of nail matrix or root), treatment of any metabolic or peripheral vascular disease or neurological condition;
- Rehabilitation therapy, which includes physical and occupational therapy, speech therapy, cardiac and pulmonary rehabilitation therapy and cognitive therapy for up to 60 outpatient visits per calendar year;

- Acupuncture or acupressure (from an In-Network provider only) with the Plan benefit limited to an allowable charge of no more than \$80 per visit with only one covered visit per day;
- Nurse midwife services (from an In-Network provider only);
- Extraordinary nutrition such as hyperalimentation or Total Parenteral Nutrition (TPN), except hyperalimentation or TPN for persons recovering from or preparing for surgery.
- Benefits will not be paid for a period longer than 3 months unless the patient is in a course of treatment which is being managed under Case Management and such continued treatment is deemed Medically Necessary by the Claims Administrator; and
- Treatment for conditions affecting the joints between the jawbone and the skull, known as temporomandibular joint and craniomandibular joint disorders.

Outpatient Surgery

Outpatient surgery refers to non-emergency surgery that is performed in a doctor's office, clinic or the outpatient facility of a hospital. Generally, outpatient surgery requires advance approval. Although an In-Network provider will get the approval for you, it's your responsibility to make sure the surgery is approved. If you use an Out-of-Network provider, you must get the necessary approval yourself. For a list of outpatient surgeries that require approval, see page 28.

Second Opinions

Before having surgery or a medical procedure, you may want to get a second opinion. If you do, you have up to six months after the initial recommendation and six months before the date of the surgery or procedure to get the second opinion.

The Plan will cover the allowable expenses of the second opinion visit and any related tests, unless the doctor providing the second opinion performs the surgery. In that case, any charges relating to the second opinion are not considered allowable expenses and will not be covered.

A third opinion is also covered if:

- The second opinion does not agree with the initial opinion; or
- The second opinion agrees with the initial opinion, but the third opinion is different.

Emergency Care

To know when to visit an emergency room, you need to understand the difference between emergency care and urgent care, especially since the Plan pays benefits for emergency care only in the case of an emergency as defined below. If you need an ambulance for emergency care in a hospital emergency room, the Plan will pay 100% of the cost.

EMERGENCY CARE

An emergency is a situation in which you have an illness or injury that you believe is life threatening or will cause you serious harm. Examples of symptoms that may require emergency care include uncontrollable bleeding and chest pains.

If you experience symptoms that a reasonable person would consider severe enough for an emergency room visit, the Plan will cover you. It does not matter if the emergency room visit is In-Network or Out-of-Network. You or someone who can speak on your behalf must call the Cigna care coordinator using the telephone numbers listed on your MILA/Cigna ID card within two business days of the emergency room visit.

Urgent Care

The need for urgent care arises if you need immediate medical attention, but the injury or illness is not life threatening or seriously harmful. Examples include a sprained ankle, a cut that requires stitches or a child with a high fever. If you need urgent care, you should go to an urgent care center as soon as possible. It does not matter if the urgent care center is In-Network or Out-of-Network. Most urgent care centers are open nights and weekends when your doctor's office may be closed. Some may be open 24 hours. To find the nearest urgent care center, call the Cigna Member Services telephone number on your ID card.

Hospital Care

There are several reasons you may be admitted to a hospital, including:

- A planned admission, for example, for non-emergency surgery;
- An emergency admission; or
- Pregnancy/maternity.

As described on pages 27-28, a planned admission always requires advance approval, and an emergency admission requires approval within two business days after the admission. A maternity admission requires approval only if the stay exceeds 48 hours (96 hours in the case of a cesarean section).

Room And Board

The Plan covers a portion of the cost of room and board for a semi-private room. If you occupy a private room, your room and board expense will be reimbursed at the hospital's semi-private rate.

Other Hospital Expenses

The Plan covers all other medically necessary hospital-supplied services and supplies needed for proper treatment and care during a hospital stay. These include eligible charges for:

- Operating room expenses;
- Lawfully prescribed medicines;
- Dressings;
- Oxygen and anesthetics and the cost of administering them;
- X-rays and other diagnostic laboratory procedures;
- Blood transfusions and the cost of blood or plasma;
- Rental or, at the Plan's option, purchase of durable medical equipment such as a knee brace for use after knee surgery; and
- Prosthetic appliances, such as an artificial limb.

Emergency Room Expenses

As explained on page 33, costs for outpatient care in a hospital emergency room are covered only if the care is received for a valid emergency.

Pre-Admission Expenses

Costs for hospital-provided services directly related to a patient's upcoming hospital stay are covered. In addition, pre-operative x-rays or other diagnostic procedures are covered if they are:

- Performed within 10 days before the hospital stay begins; and
- Directly related to the specific illness for which the patient will be receiving care in the hospital.

Physician Visits

The Plan covers the costs of any doctor or specialist visits to provide inpatient medical care, other than surgery, to a covered patient.

Surgical Costs

Covered expenses related to a surgery or operation include:

- The surgeon's immediate pre-operative examination;
- The surgical procedure itself and an assisting physician, if the procedure requires one and the hospital does not have any available staff physicians qualified to provide the needed assistance;
- The post-operative care needed for the procedure; and
- Any breast reconstruction required after a mastectomy, and the purchase of any prosthesis (artificial implants) needed as a result of a mastectomy.

If you have more than one surgical procedure performed at the same time, the maximum covered charge equals the allowable charge for the most expensive procedure plus one-half the allowable charge for each additional procedure.

Reconstructive Services and Breast Reconstruction After Mastectomy

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

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

These benefits are covered applying the same cost-sharing as is relevant to other medical/surgical benefits.

Ambulance Service

Costs are fully covered for licensed ambulance service to or from the nearest hospital, skilled nursing facility or hospice where the covered patient can get needed medical care or treat-

ment. Ambulance travel from a hospital to a skilled nursing facility is also covered 100%. Use of an ambulance when not medically necessary, or when a lower cost mode of transport would be sufficient, is not covered. Air ambulance service will be covered only when the requirement for air transport is necessitated by a valid emergency and only this form of transport will accomplish the medically necessary delivery of the patient to an adequate treatment setting.

Other Medical Services

The Plan also covers reasonable and customary expenses for the following medical services when they are medically necessary for your treatment.

Private Duty Nursing

Private nursing care from either a licensed registered nurse (RN) or nurse practitioner for medically necessary care is covered for up to 70 four-hour visits in a calendar year. However, private duty nursing care is not covered when rendered in a hospital or skilled nursing facility.

Cancer Therapy

The Plan will cover chemotherapy, radiation and other cancer treatment therapies. You can get this therapy from a hospital on an outpatient basis or from another provider.

Dental Treatment

The Medical Plan does not cover dental care except for necessary x-ray examinations and physicians' services for the removal of impacted wisdom teeth and for the treatment of accidental injuries to natural teeth, provided the expenses are not covered under any Dental Plan. In the case of an accidental injury, the expenses must relate to and be incurred within 12 months of the accident. Other dental care, including orthodontia, endodontics and periodontics, is not covered under the Medical Plan. For a description of the Dental Plan coverage, see pages 44 to 50.

Other Non-Hospital Services and Supplies

The Plan also covers the following medical services and supplies:

- X-ray and other diagnostic laboratory examinations;
- Medicines prescribed by a physician and dispensed by a licensed pharmacist, if provided through the Plan's Prescription Drug Program (beginning on page 38);

- Surgical dressings;
- Oxygen and the rental of equipment that provides oxygen;
- Treatment by a physiotherapist, if provided by someone other than you or your spouse, child, brother, sister or parent or the spouse of your parent;
- Artificial limbs, larynx and eyes;
- Electronic heart pacemaker;
- Durable equipment required for therapeutic use, such as casts, splints, trusses, braces and crutches and the rental of wheelchairs, hospital beds, etc. In order to be a covered expense, the purchase of durable medical equipment must be approved by the Cigna care coordinator;
- Prostheses necessary in connection with a mastectomy, as determined by the patient and attending physician; and
- Treatments by x-ray, radium or other radioactive substances.

Non-Routine Care And Services

Certain types of care and medical service, beyond that provided in a hospital, are covered when specifically ordered by your doctor. All of these services are subject to Plan limits and may require approval in advance, as described on pages 27–28.

Skilled Nursing Facility

Medical care and treatment provided by a skilled nursing facility are covered up to 100 days per calendar year.

Home Health Care

Covered services include up to 120 home health care visits per calendar year for:

- Part-time or intermittent nursing care by or supervised by an RN;
- Part-time or intermittent services of a home health aide; or
- Physical, occupational or speech therapy.

Necessary medical supplies or medicine prescribed by a doctor and lawfully dispensed by the home health agency and laboratory services are covered. All services must be provided under the continuous direction of a physician and included in an approved home health care plan. Each visit by a representative

of the agency will be considered one visit. However, if a home health aide visit extends beyond four hours, each additional four hours or part thereof will count as an additional visit.

Hospice Care

A covered, terminally ill patient (defined as one with a life expectancy of six months or less) is covered for hospice care services that include:

- Bed and board in a semi-private room (coverage for a private room is limited to the allowable expense);
- Services and supplies;
- Outpatient services;
- Professional services by a physician;
- Pain relief treatment including medicines and medical supplies;
- Individual and family counseling by a psychologist, social worker, family counselor or ordained minister, including up to three bereavement counseling sessions within one year after the patient's death; and
- The services listed under "Home Health Care" as described in the preceding section.

Necessary medical supplies or medicines prescribed by a doctor and lawfully dispensed by the hospice and laboratory services are covered.

Transplant Surgery

The Plan covers heart, lung, heart/lung, kidney, liver, pancreas and autologous bone marrow and stem cell transplants. To qualify for In-Network benefits for organ transplant surgery, it must be performed at a Cigna LifeSource Transplant Network® Center. Surgery at any other hospital is considered Out-of-Network and must be approved in advance by a Cigna care coordinator. In addition, if the surgery is performed anywhere but in a Cigna LifeSource Transplant Network® Center, the following maximum benefits apply:

- Heart: \$150,000;
- Lung or double lung: \$185,000;
- Heart/lung: \$185,000;
- Kidney: \$80,000;
- Liver: \$230,000; and
- Pancreas: \$50,000.

NOTE

Cigna LifeSource Transplant Network® Centers can be found by calling the number on the back of your MILA/Cigna ID card or by checking the Cigna website.

TRAVEL BENEFITS

If you live at least 60 miles from the transplant facility, travel and lodging expenses for both you and your donor are covered. If approved in advance, travel expenses to a transplant facility for pre-transplant evaluation are covered even if it is determined that the transplant is not medically appropriate.

DONOR MEDICAL BENEFITS

The Plan also covers the medical expenses for the donor if the transplant surgery is coordinated and approved by a Cigna care coordinator through the National Organ Transplant Program.

What Is Covered Under The Behavioral Health Program

Good health doesn't refer to only physical health. The state of your mental health is important too. It can affect your physical well-being as well as your success at work and your relationships with others. Substance abuse is a chemical dependency or addiction, where the body cannot control the need for alcohol or another substance.

When you or a covered family member need help with mental health issues or substance abuse, it's important to be able to get help quickly and in total confidence. That's why the MILA National Health Plan provides dedicated professional care to help deal with these problems and covers the cost of treatment.

Access to mental health services or substance abuse treatment can be obtained by calling a provider or by calling a counselor at the Member Assistance Program.

The Member Assistance Program

The Member Assistance Program (MAP) is a counseling service designed to help you with a wide variety of problems you may face. Cigna Behavioral Health (CBH) administers the MAP using specially trained and certified MAP Counselors. In addition to being trained to address mental health and substance abuse issues, the counselors may provide assistance with the following types of problems:

- Financial counseling on mortgage selection and evaluation or household budgeting;
- Child care and elder care provider selection;
- Marriage counseling;
- Workplace problem resolution; and
- Many other problems.

If you have something that is troubling you, consider calling a counselor at the MAP.

All care is confidential. No one (not even your employer or the MILA Fund Office) besides you, your treatment provider and Cigna knows what treatment you are getting, or why you are being treated.

To access care, simply call the MAP 24 hours a day, seven days a week, at the toll-free number you'll find in the MILA Resources chart in the Administrative Information section at the back of this SPD. A MAP Counselor will discuss your concerns, answer your questions and, if appropriate, coordinate approval of and a plan for care or treatment. Up to three consultations per crisis will be covered in the MAP at no charge to you. If appropriate, the MAP Counselor will refer you to a Cigna Behavioral Health Manager.

Approval For Behavioral Health Care

Approval requirements for coverage of Behavioral Health treatment or other services are similar to those in the balance of the Medical Plan. Approval is always required for institutional care and for intensive therapy. The important issues in securing necessary approval are (1) who may request approval and (2) when must that approval be secured.

When you are referred to a Cigna Behavioral Health Manager by a MAP Counselor, approval for inpatient treatment will always be accomplished by that MAP Counselor at the time of the referral and the referral will be made to an In-Network provider. The MAP Counselor will always secure approval for behavioral health services on a completely confidential basis.

Alternatively, either you or your referring physician may call a Cigna Behavioral Health Manager directly. If you or your

physician contacts a provider directly, no prior approval is required for the initial outpatient treatment. The charges will be covered depending upon whether the provider is In-Network or Out-of-Network. If you are covered in the Premier plan or the MILA Medicare Wrap-Around plan, both In-Network and Out-of-Network provider's charges will be covered, subject to any applicable copays or deductibles and coinsurance. If you are covered in either the Basic plan or the Core plan, only In-Network provider's charges will be covered, subject to any applicable copays or deductibles and coinsurance.

If you are to be admitted to an institution or to have institutional care, or your procedure, treatment or service is extensive and requires advanced approval for the extended procedure, treatment or service, and you do not contact a Cigna Behavioral Health Manager before treatment begins, your benefits may be reduced.

The Plan will reduce your normal reimbursement by 20% of the amount of the eligible charge if:

- You do not call for approval at least four business days before being institutionalized (or for a valid emergency, within two business days following admission) or for any extension of the originally approved length of stay before such extension begins; and
- You do not call for approval before receiving extended counseling treatment where approval is required.

If you call for approval, but the care you request is reviewed by the Cigna Behavioral Health Manager and found not to be medically necessary, the care will not be covered. Any additional expenses you have to pay because you did not get proper approval do not count toward your deductible, annual out-of-pocket maximum or the Plan's coordination of benefits provision.

What Treatment Is Covered

In many ways, behavioral health coverage is similar to your regular medical coverage. If you are covered in the Premier plan or the MILA Medicare Wrap-Around plan, you may receive care from any doctor, hospital or treatment provider you wish. If you are covered in the Basic or Core plan, only services rendered by In-Network providers are covered. As in the Medical Plan, the amount you pay for services and the limits on your coverage depend on whether you receive care from a Cigna In-Network provider or an Out-of-Network provider.

Coverage for autism is provided in the Plan, in contrast to other areas of behavior dysfunction that result from organic conditions that are excluded from coverage (for example, organic brain syndrome, Alzheimer's condition and mental retardation). Coverage for autism will include the following:

- Medically necessary habilitative therapy (that is, speech therapy, physical therapy and occupational therapy) in the treatment of autism; and
- Medically necessary treatment of behavioral dysfunction that has resulted from autism including coverage for Autism Spectrum Disorder and for Applied Behavioral Analysis (ABA) Therapy.

The coverage for the treatment of autism will not serve to expand coverage for other conditions such as developmental delays or learning disabilities beyond coverage otherwise available in the Plan.

Plan Limits

In-Network benefits payable under the Plan are unlimited to the extent they are medically necessary. A Cigna Behavioral Health Manager must determine if inpatient days or outpatient visits are medically necessary or appropriate based upon professional standards and protocols in the geographic area in which the treatment is rendered. Without this approval, you are responsible for any additional charges.

The Prescription Drug Program

All eligible MILA Members receive prescription drug coverage through CVS Caremark, unless you are covered as an eligible dependent of a participating employee who has elected separate prescription drug coverage that has been approved by the Trustees, prescription drug coverage is the same whether you are covered under the Premier, Basic or MILA Medicare Wrap-Around plans. The copayment amounts are higher and the deductible operates differently if you are covered by the Core plan.

Types Of Prescription Drugs

Covered prescription drugs are divided into three categories: generic, preferred brand and non-preferred brand drugs. The amount you pay for a prescription depends on the drug's category.

- **Generic Drugs:** These are labeled with the drug's basic chemical name and usually have a brand name equivalent. (For example, Lipitor is the brand name for the generic drug atorvastatin.) A generic drug must, by law, contain the same active ingredients as its brand name equivalent. In addition, it must be equivalent in strength and dosage. Generic drugs are the most affordable way for you to obtain quality prescription drugs at your lowest copayment level.

- **Preferred Brand Drugs:** These are brand name prescription drugs that either don't have a generic equivalent or are considered to be an effective alternative under the formulary. You are covered for these drugs at a slightly higher copayment than for generic drugs.
- **Non-Preferred Brand Drugs:** These are brand name prescription drugs that can generally be effectively substituted with a preferred brand or generic drug from the formulary. This category of drugs has the highest copayment amount.

Prescription Brand Deductible And Generic Substitution

If you are a Member of the Premier, Basic or the MILA Medicare Wrap-Around Plan, you will pay a \$500 family deductible for all brand name drugs when a generic equivalent is available ("multi-source brand drug") and the prescribing physician directs that only the brand may be issued (either by indicating "Dispense As Written" [DAW] or otherwise). However, if the prescribing physician provides a written statement which is satisfactory to the Claims Administrator that you cannot take the generic drug for medical reasons unique to your situation, the multi-source brand drug will be issued and the deductible will be waived for that prescription.

If the prescribing physician has not marked the multi-source brand drug as DAW, the Plan requires that the pharmacist substitute the generic drug for the brand name drug to which it is equivalent when the prescription is filled. You will save money because you will be charged the generic copay instead of the brand copay. However, if you insist on the multi-source brand drug being issued, you will be charged the brand copay plus the excess cost of the multi-source brand drug. The Plan will pay only what it would have paid if the generic had been substituted.

After your family meets the deductible amount for multi-source brand drugs for the year, you pay the copay amount shown in the Premier, Basic or MILA Medicare Wrap-Around Plan Benefits Summaries. The copay amount depends on the type of drug you purchase and whether you purchase the drug (1) from a retail pharmacy or (2) through the mail service or the Maintenance Choice program. This deductible is applied to all multi-source brand drug prescriptions filled at a retail pharmacy or at the CVS Caremark Mail Service Pharmacy. It does not apply if you fill a prescription for a generic drug or a brand name drug for which there is no generic equivalent drug.

If you are a Member of the Core Plan, the \$500 deductible applies to each individual and it applies to all brand name drugs

even if a generic equivalent does not exist. You will continue to pay the cost of all brand name drugs until the \$500 deductible has been met. After that, the Plan will pay the balance of the cost of the brand name drugs after you have paid your copay.

Purchasing Prescriptions

When you receive a prescription from your physician, you may fill it through any of the following:

- The CVS Caremark retail network of participating pharmacies for up to a 30-day supply;
- Any other retail pharmacy that is not part of the CVS Caremark retail pharmacy network for up to a 30-day supply;
- At CVS retail pharmacies using the Maintenance Choice Program for up to a 90-day supply; or
- Through the CVS Caremark Mail Service Pharmacy for up to a 90-day supply.

NOTES

Generally, you may refill a prescription through a retail pharmacy only once. After that, you must use the CVS Caremark Mail Service Pharmacy or the Maintenance Choice Program in order for the Plan to cover your prescription. These programs generally provide you with the lowest cost and the most convenient prescription delivery method.

Using An In-Network Retail Pharmacy

If you have a prescription filled (or refilled) at a participating retail pharmacy in the CVS Caremark Pharmacy Network, you pay the copayment amounts listed in the benefits summary for your benefit plan. Just show your CVS Caremark prescription ID card to the pharmacist and pay your applicable copay; the Plan pays the rest.

Remember, a prescription drug deductible may apply depending on the type of drug you are purchasing. See the discussion above for details about how the prescription drug deductible works.

Using An Out-Of-Network Retail Pharmacy

When you fill a prescription at a retail pharmacy that does not

participate in the CVS Caremark Network, you pay the full cost of the prescription drug when you have the prescription filled. You must obtain a detailed receipt for each prescription drug that you purchase. Then you must complete a claim form supplied by CVS Caremark or MILA and send the claim form and each receipt from the pharmacy to CVS Caremark for processing. The receipts must include the following:

- The name and address of the dispensing pharmacy;
- The prescription number;
- The name of the drug;
- The quantity dispensed;
- The date the prescription was filled;
- The cost of the prescription;
- The physician name, address and NPI number; and
- Medication NDC number.

You can receive claim forms by calling the telephone number on your ID card, through CVS Caremark's website www.caremark.com or from MILA. Mail your claim form and pharmacy receipt to CVS Caremark at the address shown on the form. CVS Caremark will deduct the appropriate copay and then reimburse you up to the amount the prescription would have cost at an In-Network pharmacy. **You are responsible for any additional cost.**

For example, let's say a preferred brand drug costs \$200 at an In-Network pharmacy and \$250 at an Out-of-Network pharmacy. As a MILA National Health Plan participant (the Core Plan copay differs), you would pay only \$10 at the In-Network pharmacy and the Plan would pay \$190. At the Out-of-Network pharmacy, you would pay \$250, then file a claim along with the pharmacy receipt and wait for reimbursement. The Plan would pay you \$190, and you would be responsible for \$60 (\$250 minus \$190).

Using The Mail Service

Using the CVS Caremark Mail Service is easy and convenient. As discussed previously, you must use the CVS Caremark Mail Service or the CVS Caremark Maintenance Choice Program to fill most prescriptions after they have been filled at retail and refilled once. If you refill a prescription at retail after the first refill, it will not be covered by the Plan. The easiest way to begin using the mail service when your physician prescribes a medication which requires more than one refill is to request a second prescription when your physician writes the first one.

- The first prescription will be for a 30-day supply of medication and it will allow for one refill. If your physician is certain that the medication prescribed will not have to be adjusted or changed, your physician will give you the second one immediately. Otherwise, your physician will provide it to you after it is certain the prescribed medication is performing as expected.
- The second prescription should be for a 90-day supply and it should allow for refills. This second prescription should be sent to CVS Caremark together with a mail service prescription drug form with your payment.

If you supply CVS Caremark with your credit card information, it will be easier to pay the cost for this prescription and it will allow you to refill your prescription over the telephone or online at www.caremark.com.

Allow at least five to ten days for your medication to arrive. Many people request a refill when they have a two week supply remaining to ensure that their medication supply does not run out. Your order will be delivered to your mailing address with postage paid in full. It is up to you to request a refill before your current prescription supply runs low to ensure that you can continue to take your medications without interruption.

NOTE

You can get a mail service prescription drug form by calling CVS Caremark, going to CVS Caremark's website or going to MILA's website and clicking on "Forms" and then "CVS/Caremark Rx Claim Form." Send your completed mail order form(s) along with the associated prescription from your doctor and payment for your copay and any applicable deductibles to:

CVS Caremark
PO Box 2110
Pittsburgh, PA 15238-2110

MILA/CVS Caremark Maintenance Choice Program

You have a choice of receiving your long term prescription drugs (maintenance drugs), for up to a 90-day supply, at either a CVS retail store under the Maintenance Choice Program or through the CVS Caremark Mail Service Pharmacy.

Your prescription benefit Plan will allow only two 30-day fills at a retail pharmacy (the initial prescription fill and one refill).

Thereafter, the Plan will only cover up to a 90 day refill either (1) through the CVS Caremark Mail Service Pharmacy or (2) through a local CVS Pharmacy under the CVS Caremark Maintenance Choice Program. You pay the same lower mail service copay when you receive your prescription through either program.

Mail Order Service Or Maintenance Choice

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

- If you currently receive your long-term drugs from CVS Caremark Mail Service and wish to continue—no action is required.
- If you want to change how you receive your long-term drugs by switching from the CVS Caremark Mail Service to a CVS Pharmacy under the Maintenance Choice Program, call CVS Caremark Customer Care toll free at **1-866-875-MILA (6452)** and the Customer Care Representative will take care of it for you. The Representative will contact you after your last allowable fill through the Mail Service and with your permission, will contact your doctor to get a 90-day prescription 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 (6452)**. CVS Caremark Customer Service is open 24 hours a day, seven days a week. Alternatively, you can visit www.caremark.com.

When You Must Use The Mail Service Or The Maintenance Choice Program

Except for insulin and the other prescription drugs listed below that you can buy either at a retail pharmacy or through the mail, all maintenance drugs must be ordered through the Plan's CVS Caremark Mail Service or Maintenance Choice Program after they have been filled and refilled once. Examples of maintenance drugs that must be filled through one of these Programs are:

- Prescription drugs taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes and asthma.
- Diabetic blood sugar level test strips must also be ordered through these programs.

To get started, you may fill an initial prescription of a maintenance drug in person at a pharmacy and receive up to a 30-day supply. You also may order one refill at a retail pharmacy. After

that, you must order refills through either CVS Caremark Mail Service or Maintenance Choice Program. Except for prescription drugs that are identified as “specialty” or are required for chemotherapy, mail service and Maintenance Choice refills are limited to a 90-day supply.

Exceptions To Mandatory Mail And Maintenance Choice

Although you may choose to use the CVS Caremark Mail Service or Maintenance Choice Program because they are more convenient for you, the following prescription drugs are exceptions to the mandatory use of these programs. Prescriptions for the following items must be obtained at a retail pharmacy:

- Miacalcin;
- Xalatan;
- Anti-infectives (antibiotics, anti-fungals and anti-virals);
- Topical medications (creams, gels and ointments);
- Vaginal medications (creams, gels and ointments);
- Controlled substances; and
- Cough and cold medications.

Paying For Your Prescription Drugs Through The Mail Service Pharmacy

To receive an estimate of the total cost of your prescription drug order, you may call CVS Caremark Customer Care at 1-866-875-MILA (6452). If your order includes drugs that are subject to the Plan’s \$500 prescription drug deductible, the quote should be regarded as an estimate. The cost of drugs changes frequently and the price you pay is the price on the day the prescription is shipped to you.

The fastest and easiest way to fill your prescription is to supply your credit card number to CVS Caremark so your prescription

will be filled immediately. You will receive a receipt with your prescription from CVS Caremark showing the actual amount charged to your credit card. You may place your credit card number on file with CVS Caremark so that future purchases will be expedited.

You may opt to pay for your prescriptions by check or money order. However, due to the variation in drug costs from day to day, you may want to establish a small account with CVS Caremark so funds are available as needed. CVS Caremark will not release any prescriptions unless there are sufficient funds in your account to cover your total cost for the prescription order. If your payment is insufficient to cover the cost of your prescription(s), a Member Accounts Receivable (AR) Representative may contact you to explain additional payment options that will expedite the shipment of your order.

Covered Prescription Drugs

A prescription drug means any drug that may be legally dispensed only when you have a written prescription from a physician or other licensed medical provider. The physician may also call in a prescription directly to your local pharmacy or the CVS Caremark Mail Service Pharmacy. Insulin and other supplies for diabetes, such as syringes, needles and testing materials, are also covered.

When you get a prescription, the pharmacist will fill it with a generic drug unless no generic drug exists for that brand or the prescribing physician has specified “Dispense As Written” (DAW). If there is no generic equivalent for a brand name drug, the brand name will be provided as ordered and covered under the Plan. If there is a generic equivalent, the cost of the prescription will be subject to the \$500 deductible.

Specialty Medications

Specialty medications are used to manage long-term (chron-

Examples Of Process When Paying For Prescriptions By Check Or Money Order			
Estimated Quote by CVS Caremark	Actual Cost of Rx Order	Difference	End Result
\$125.00	\$118.00	\$7.00 credit	Balance will be placed into an account at CVS Caremark to be applied to future purchases. Prescription shipped immediately.
\$125.00	\$125.00	\$0.00	Paid in full. Prescription shipped immediately.
\$125.00	\$128.50	\$3.50 due to CVS Caremark	Balance must be paid before prescription will be shipped.

ic), rare and complex conditions or genetic disorders. These include rheumatoid arthritis, cancer, multiple sclerosis, growth hormone disorders, immune deficiencies, and more. The medications are often injectable or intravenously (IV) infused, but may also be in oral or inhaled form. These medications typically have special storage and handling needs and cost more than other drugs because of the way the drugs are made.

As a part of your pharmacy benefit, specialty medication services are available to you exclusively through the Caremark Specialty Pharmacy. CVS Caremark Specialty Pharmacy is the specialty pharmacy provider for CVS Caremark, providing special support for patients taking specialty medications, including 24-hour access to pharmacy services and emergency pharmacist consultation, as well as ongoing support and counseling.

Additionally, Caremark's Specialty Connect program offers you flexibility and choice, making it easier and more convenient for you to drop off and pick up your specialty prescriptions either through a CVS pharmacy or by mail. After you drop off a specialty prescription at a CVS pharmacy, the prescription is transferred to the Caremark Specialty Pharmacy for filling. The filled prescription is then either sent back to your CVS pharmacy for pick-up (except in West Virginia, Arkansas and Oklahoma) or mailed directly to you, depending on which method you choose. Learn more about the CVS Caremark Specialty Pharmacy at www.caremark.com/specialty.

For a list of medications that must be dispensed by CVS Caremark Specialty Pharmacy, log onto www.caremark.com or call 1-800-237-2767. Since the list is subject to change, you may wish to call 1-800-237-2767 for the most current list of covered specialty medications dispensed by the CVS Caremark Specialty Pharmacy.

In general, the drugs on this list will not be covered by any pharmacy except for CVS Caremark Specialty Pharmacy regardless of their medical necessity, their approval, or whether you have a prescription written by a physician or other provider. In limited circumstances, however, coverage may be allowed through an alternate provider. Those circumstances include:

- Specialty medications billed by a facility as part of an inpatient hospital stay;
- Specialty medications billed as part of an emergency room visit;
- Situations where Medicare is the primary carrier;
- Limited distribution specialty medications where CVS Caremark does not have access to the drug;

- When homecare is not clinically appropriate (either due to the Member's clinical history or due to characteristics of the drug which require special handling) and an alternative infusion site (that is qualified to administer the drug) is not available for coordination of services within a reasonable proximity (30 miles or less). The situation will be evaluated by CVS Caremark clinical staff; and
- The treating physician provided written documentation outlining the clinical rationale for the requirement that the Member be treated at the designated facility and confirming that the designated facility is unable to accept drug dispensed by CVS Caremark. The written documentation will be reviewed and approved by appropriate CVS Caremark clinical personnel before allowing coverage for the requesting provider under the medical benefit. The situation will be evaluated by CVS Caremark clinical staff.

Select specialty medications covered only under the pharmacy benefit through CVS Caremark Specialty Pharmacy are excluded from coverage under the Medical Plan.

Prior authorization may be required for any specialty medication, regardless of whether it is filled through the Prescription Drug Plan or the Medical Plan.

The Caremark Specialty Pharmacy program not only provides specialty medications, but also provides personalized pharmacy care management services as follows:

- Access to an on-call pharmacist 24 hours a day;
- Convenient, prompt and discreet delivery;
- Disease-specific education and counseling;
- Proactive refill reminder phone calls;
- Benefit verification and reimbursement support;
- Coordination of patient care with physician's office; and
- Caremark Specialty supports safe, clinically appropriate and cost-effective specialty medications and may make calls to your physician about your therapy. As a result, your physician may decide to make changes in your therapy.

The Caremark Specialty Pharmacy program encourages the use of a drug on the Preferred Drug List prior to the use of medicines that are not on the Preferred Drug List. If you have not tried the drug on the Preferred Drug List, a Prior Authorization must be completed before the non-preferred medicine will be covered. This means that the Caremark Specialty Pharmacist

will speak with your physician about the medication choices but only your physician can decide which drug you will receive.

Specialty services are available toll-free at **1-800-237-2767**, through CaremarkConnect, Monday through Friday from 6:30 a.m. to 8 p.m. (Central Time). For those plan participants requiring telecommunications device (TDD) assistance, please dial toll-free 1-800-231-4403.

Quantity Restrictions On Covered Medications

There may be quantity limits on certain medicines. Quantity limits are based on the Food and Drug Administration's (FDA) recommended dosing guidelines for each medication and are reviewed regularly by CVS Caremark to ensure clinical appropriateness. Limits are set to ensure safety and efficacy in the treatment of various health conditions. Medicines that have limits on the quantity allowed are less than the standard, which is a thirty (30) day supply. For specific medicine limitations, please log in to www.caremark.com or call Caremark at **1-866-284-9226**. Quantity limits may change periodically based on updates from the FDA's recommended dosing guidelines.

Examples of drug categories with quantity restrictions:

- Beta-Agonists and Combinations;
- Sexual Dysfunction Agents—limited to six (6) pills/doses in a 30-day period;
- Intra-nasal Corticosteroids (Allergies);
- Mast Cell Stabilizers and Anticholinergics;
- Influenza Treatment and Prevention;
- Insomnia Agents;
- Glucose Monitors; and
- Opioids and Pain Medications (including those containing Acetaminophen, Aspirin or Morphine).

When To Get Prior Approval For A Prescription

Certain prescription drugs must be approved for coverage before you fill a prescription. These drugs include but are not limited to:

- Alglucerase (treatment for liver, spleen and bone marrow conditions);
- Erythropoetin (used to treat anemia associated with HIV or its treatments);
- Filgrastim (helps the body make white blood cells to prevent infections);

- GM-CSF (used to treat non-Hodgkin's lymphomas and leukemia);
- Growth hormones;
- Octreotide (used on growth hormones, certain tumors and gastrointestinal problems);
- All compound drugs costing more than \$300 for a 30-day supply (adjusted pro-rata for the quantity); and

To get approval for any of the above prescription drugs, your doctor or provider should call CVS Caremark at the toll-free number shown on the chart in the Administrative Information section of this SPD.

When Covered By More Than One Prescription Drug Plan

The MILA Prescription Drug Program contains a coordination-of-benefits (COB) provision which establishes the order in which benefit plans will pay for the cost of prescription medication. The purpose of this provision is that you will receive the best coverage provided by either plan for your prescription drugs while saving MILA where possible. See page 60 for more information regarding the order of plan payment.

You must tell MILA if you have another prescription drug program in order for this program to operate properly. MILA will report to CVS Caremark the order in which the plans are to pay for each covered person based upon the rules in the plan referred to above. When you submit a drug for payment to the retail pharmacy, give copies of your drug cards for each plan to the pharmacist. Many retail pharmacies (including most CVS Retail Pharmacies) are equipped to process both plan benefits electronically so that most of the coordination will be invisible; you will just pay the lowest copay provided by either plan when you receive your prescription drug.

However, if the pharmacy is not equipped to perform the COB process, it will process the prescription under the plan that is primary and charge that plan's copayments or other costs. You should then obtain a receipt just as if you were using an "Out-of-Network" pharmacy and submit your claim together with your receipt to the secondary plan. If the MILA Plan is secondary, you may obtain the claim form online or by calling MILA.

The MILA Dental Plan

Dental Benefits are treated as a standalone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA) because they are separately administered by Aetna.

Plan benefits shall be provided through a network of dentists as contracted and administered by Aetna, the Claims Administrator for the MILA Dental Plan. Benefits shall be available from any dentist whose license would permit the provision of the services and supplies. However, if the provider is not in the contracted Aetna network, the eligible charge for such service or supply shall be limited to the amount that would have been eligible for the service or supply that would have been covered by the Plan had the service been performed or the supply provided by an Aetna contracted network dentist who was qualified to perform the eligible work in the geographic area in which it was performed or supplied.

Dental Benefit Payable Under The Plan

The following benefits will be payable for covered services under the Plan. The eligible charge will be limited to the lesser of (1) the actual charge made by the dentist for the service or supply and (2) the eligible contracted charge. The eligible contracted charge will be based on whether the service was performed or the supply was provided by a contracted network dentist who was qualified to perform the eligible work in the geographic area in which it was performed or supplied.

- **Calendar Year Deductible.** You must pay a calendar-year deductible for all covered Basic Restorative Care and Major Restorative Care Services before any such benefits will be payable. The deductible will not apply to Diagnostic and Preventive Care and Orthodontic Care. The deductible is \$25 per member of your family per calendar year. No more than an aggregate family limit of \$75 in deductible expenses will be charged to your family during a calendar year, regardless of the number of your family members who incur such expenses. It is not necessary that any individual satisfy an individual deductible if your family first satisfies the family limit of deductible expenses.
- **Diagnostic and Preventive Care Coinsurance.** Expenses incurred for Diagnostic and Preventive Care shall be reimbursed at 100% but no more than the Plan's maxi-

imum benefit will be paid for expenses incurred during the calendar year.

- **Basic Restorative and Major Restorative Care Coinsurance.** Expenses incurred for Basic Restorative Care and Major Restorative Care shall be reimbursed at 85% but no more than the Plan's maximum benefit will be paid for expenses incurred during the calendar year.
- **Orthodontic Care Coinsurance.** Expenses incurred for Orthodontic Care shall be reimbursed at 85% but no more than the Plan's maximum lifetime benefit will be paid for expenses incurred during the individual's lifetime. Adult orthodontia will be covered up to the maximum lifetime benefit for medically necessary treatment only.
- **Maximum Dental Plan Benefit.** The Plan shall pay no more than \$2,500 in reimbursement for Preventive, Basic and Major dental expenses incurred by an individual during a calendar year. In addition, the Plan shall pay no more than \$1,500 in reimbursement for Orthodontic dental expenses that are incurred by an individual during that individual's lifetime.
- **Dental Implants.** The Plan will cover up to a \$5,000.00 annual maximum for implant services, including the surgical implant procedure, subsequent maintenance visits, cleaning and repairing and/or replacement of screws and attachments. Implant replacement will be covered only if the original implant is neither serviceable nor repairable and the implant to be replaced was originally installed at least five years prior to the date of the replacement.

Covered Dental Services

The following services or supplies shall be eligible under the Plan, subject to the limitations and exclusions set forth on pages 48–50 and 58–59. Further, for a service or supply to be covered:

- It must be a covered expense as listed in this Plan; its provision must not be excluded as provided in this Plan; its cost must not exceed the aggregate amount available for such service as provided in this Plan; and it must be obtained in accordance with all the terms, policies and procedures provided for such service or supply in this Plan.
- The service or supply must be provided while coverage under this Plan is in effect.
- The services and supplies must be Medically Necessary. Dental services or supplies will be considered Medically Necessary if they meet all of the following conditions: (1)

they are provided by a licensed provider who is qualified to perform the service or to provide the supply; (2) the provider exercises prudent clinical judgment in selecting the service or supply for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms in the judgment of the Claims Administrator and (3) the service or supply must meet the following conditions in the judgment of the Claims Administrator:

- It must be provided in accordance with generally accepted standards of dental practice;
- It must be clinically appropriate in terms of type, frequency, extent, site and duration, and it must be considered effective for your illness, injury or disease;
- It must not have been provided primarily for your convenience, the physician or dental provider or other health care provider; and
- It must not be more costly than an alternative service or sequence of services that would likely have produced an equivalent therapeutic or diagnostic result in light of your illness, injury or disease.



Obtaining A Pre-Treatment Estimate

The purpose of the pre-treatment estimate is to determine, in advance, the benefits the Plan will pay for proposed services. Knowing ahead of time which services are covered by the Plan, and the benefit amount payable, helps you and your dentist make informed decisions about the care you are considering.

It is important to note that the pre-treatment estimate process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When To Request A Pre-Treatment Estimate

A pre-treatment estimate is recommended whenever a course of dental treatment is likely to cost more than \$300. Ask your dentist to write down a full description of the treatment you need, using either an Aetna claim form or an American Dental Association approved claim form. Then, before actually treating you, your dentist should send the form to Aetna.

Aetna may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment Plan and provide you and your dentist with a statement outlining the benefits payable by the Plan. You and your dentist can then decide how to proceed.

The pre-treatment estimate is voluntary. It is a service that provides you with information that you and your dentist can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, Aetna will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. See the Alternate Treatment (or Substitution) Rule, page 49, for more information regarding alternate treatment provisions of the Plan.

In Case Of A Dental Emergency

The Plan pays a benefit at the network level of coverage even if the services and supplies were not provided by a network provider up to the Dental Plan maximum. The care provided must be a covered service or supply. You must submit a claim to Aetna describing the care given. Additional dental care to treat your dental emergency will be covered at the appropriate coinsurance level for the type of service provided.

A Dental Emergency is any dental condition that occurs unexpectedly, requires immediate diagnosis and treatment in order to stabilize the condition, and is characterized by symptoms such as severe pain and bleeding.

COVERED DENTAL SERVICES UNDER THIS PLAN

Diagnostic and Preventive Care

Office Visits	<ul style="list-style-type: none"> ■ Routine comprehensive or recall examination—limited to 2 visits in a 12-month period ■ Problem-focused examination—limited to 2 visits in a 12-month period ■ Prophylaxis (adult or child treatment during office visit)—limited to 2 treatments in a 12-month period ■ Topical application of fluoride—limited to 1 course of treatment in a 12-month period and limited to treatment of children under age 16 ■ Sealants (per tooth)—limited to 1 application every 36 months on permanent molars only and limited to treatment of children under age 16
X-rays	<ul style="list-style-type: none"> ■ Periapical x-rays—single films up to a total of 13 films per visit ■ Bitewing x-rays—limited to 2 sets in a calendar year ■ Complete x-ray series, including bitewings, if necessary, or panoramic film—limited to 1 set every 36 months ■ Vertical bitewing x-rays—limited to 1 set every 36 months
Space maintainers	<p><i>Only covered when needed to preserve space resulting from premature loss of primary teeth. The procedure includes all adjustments which occur within 6 months of the installation.</i></p> <ul style="list-style-type: none"> ■ Fixed unilateral or bilateral space maintainers ■ Removable unilateral or bilateral space maintainers

Basic Restorative Care

Visits	<ul style="list-style-type: none"> ■ Professional visits after hours—payment will be based upon the greater of the service rendered or the visit charge ■ Emergency palliative treatment—paid per visit
X-ray and Pathology	<ul style="list-style-type: none"> ■ Intra-oral, occlusal view, maxillary or mandibular ■ Upper or lower jaw, extra-oral ■ Biopsy and histopathologic examination of oral tissue
Oral Surgery	<ul style="list-style-type: none"> ■ Extractions—erupted tooth or exposed root ■ Extractions—coronal remnants ■ Extractions—surgical removal of erupted tooth/root tip ■ Impacted teeth—removal of tooth (soft tissue) ■ Odontogenic cysts and neoplasms—incision and drainage of abscess ■ Odontogenic cysts and neoplasms—removal of odontogenic cysts or tumor
Other surgical procedures	<ul style="list-style-type: none"> ■ Alveoplasty, in conjunction with extractions—per quadrant ■ Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces—per quadrant ■ Alveoplasty, not in conjunction with extractions—per quadrant ■ Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces—per quadrant ■ Sialolithotomy: removal of salivary calculus ■ Closure of salivary fistula ■ Excision of hyperplastic tissue ■ Removal of exostosis ■ Transplantation of tooth or tooth bud ■ Closure of oral fistula of maxillary sinus ■ Sequestrectomy ■ Crown exposure to aid eruption ■ Removal of foreign body from soft tissue ■ Frenectomy ■ Suture of soft tissue injury

Periodontics	<ul style="list-style-type: none"> ■ Occlusal adjustments (other than with an appliance or by restoration) ■ Root planing and scaling, per quadrant—limited to 4 separate quadrants every 24 months ■ Root planing and scaling, 1 to 3 teeth per quadrant—limited to 1 per site every 24 months ■ Gingivectomy, per quadrant—limited to 1 per quadrant every 36 months ■ Gingivectomy, 1 to 3 teeth per quadrant—limited to 1 per site every 36 months ■ Gingival flap procedure, per quadrant—limited to 1 per quadrant every 36 months ■ Gingival flap procedure, 1 to 3 teeth per quadrant—limited to 1 per site every 36 months ■ Periodontal maintenance procedures following active therapy shall be limited to 2 procedures in a 12-month period ■ Localized delivery of antimicrobial agents
Endodontic	<ul style="list-style-type: none"> ■ Pulp capping ■ Pulpotomy ■ Apexification/recalcification ■ Apicoectomy ■ Root canal therapy, including necessary x-rays—anterior or bicuspid
Restorative dentistry	<p><i>Excluding inlays, crowns (other than prefabricated stainless steel or resin) and bridges. Multiple restorations in 1 surface will be considered one restoration.</i></p> <ul style="list-style-type: none"> ■ Amalgam restoration ■ Resin-based composite restorations (other than for molars) ■ Pins—pin retention, allowed per tooth in addition to amalgam or resin restoration ■ Crowns when tooth cannot be restored with a filling material—including prefabricated stainless steel or prefabricated resin crown (excluding temporary crowns) ■ Recementation including inlay, crown and bridge
Major Restorative Care	
Oral Surgery	<ul style="list-style-type: none"> ■ Removal of impacted teeth (partially bony) ■ Removal of impacted teeth (completely bony)
Periodontics	<ul style="list-style-type: none"> ■ Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant, limited to 1 site, in a 36 month period ■ Osseous surgery, including flap and closure, limited to 1 per quadrant, in a 36 month period ■ Soft-tissue graft procedures ■ Clinical crown lengthening, hard tissue ■ Full mouth debridement, limited to once every 36 months
Endodontic	<ul style="list-style-type: none"> ■ Root canal therapy, including necessary x-rays ■ Molar root canal therapy, including necessary x-rays
Restorative	<p><i>This category includes inlays, onlays, labial veneers and crowns only when they are employed as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 5 years [see replacement rule])</i></p> <ul style="list-style-type: none"> ■ Inlays/Onlays ■ Labial veneers <ul style="list-style-type: none"> ○ Laminate—chairside ○ Resin laminate—laboratory ○ Porcelain laminate—laboratory ■ Crowns <ul style="list-style-type: none"> ○ Resin ○ Resin with noble metal ○ Resin with base metal ○ Porcelain/ceramic substrate ○ Porcelain with noble metal ○ Porcelain with base metal ○ Base metal (full cast) ○ Noble metal (full cast) ○ 3/4 cast metallic or porcelain/ceramic ■ Post and core ■ Core buildup, including any pins

Prosthodontics	<ul style="list-style-type: none"> ■ Bridge abutments (See Inlays and Crowns) ■ Pontics <ul style="list-style-type: none"> ○ Base metal (full cast) ○ Noble metal (full cast) ○ Porcelain with noble metal ○ Porcelain with base metal ○ Resin with noble metal ○ Resin with base metal ■ Removable bridge (unilateral)—one-piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics ■ Dentures and partials—fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible <ul style="list-style-type: none"> ○ Complete upper denture ○ Complete lower denture ○ Partial upper or lower, resin base (including any conventional clasps, rests and teeth) ○ Stress breakers ○ Interim partial denture (stayplate), anterior only ○ Office reline ○ Laboratory reline ○ Special tissue conditioning, per denture ○ Rebase, per denture—adjustments to denture more than 6 months after installation ■ Full and partial denture repairs <ul style="list-style-type: none"> ○ Broken denture, no teeth involved ○ Repair cast framework ○ Replacing missing or broken teeth, each tooth ○ Adding teeth to existing partial denture—each tooth and each clasp ■ Repairs: crowns and bridges ■ Occlusal guard (for bruxism only), limited to 1 every 36 months
General anesthesia and intensive sedation	Only when Medically Necessary and only when provided in conjunction with a covered surgical procedure
Orthodontic Care	
Interceptive orthodontic treatment	
Limited orthodontic treatment	
Comprehensive orthodontic treatment of dentition	
Post-treatment stabilization	
Removable appliance therapy to control harmful habits	
Fixed-appliance therapy to control harmful habits	

Limitations On Covered Dental Services

The following services or supplies shall be limited as provided in the following treatment rules:

- **Orthodontic Treatment Rule.** Orthodontic treatment is covered when the course of treatment is performed on a covered adult (if medically necessary), or a covered child and the treatment begins prior to your child's attaining age 26. The Plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before the patient became covered by this Plan (see the Orthodontic Replacement Rule on page

49). The Plan does not cover the following orthodontic services or supplies:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;

- Treatment of micrognathia;
 - Treatment of macroglossia;
 - Lingually-placed direct bonded appliances and arched wires (i.e., “invisible braces”); or
 - Removable acrylic aligners (i.e., “invisible aligners”).
- **Replacement Rule.** Crowns, inlays, onlays and veneers, dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services are subject to the Plan’s Replacement Rule. Certain replacements of, or additions to, existing crowns, inlays, onlays and veneers, dentures, or bridges will be covered only if the Claims Administrator receives proof that:
 - While covered by the Plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
 - The present crown, inlays, onlays and veneers, dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic service was installed at least 5 years before its replacement and it cannot be made serviceable.
 - You had a tooth (or teeth) extracted while you were covered by the Plan. Your present denture is a temporary one that replaces the tooth (or teeth) replacing at least 1 of the 6 anterior (front) teeth. A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.
 - **Orthodontic Replacement Rule.** The Plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you or your child became covered by this Plan. This Plan’s coverage will be provided pro rata for the remainder of the period of orthodontia as if it had been the sole coverage since the beginning of the orthodontic treatment but the Plan’s liability shall be limited to payment for the remaining treatment in the orthodontic treatment plan.
 - **Alternate Treatment (or Substitution) Rule.** The Plan covers the closed list of procedures that are provided in the list of covered dental services on pages 46-48. You and your dental provider shall determine the course of treatment that is acceptable. When there are several ways in which to treat a dental problem, all of which would produce an acceptable result, the Claims Administrator will limit the Plan’s coverage to the cost of the least

expensive service or supply that would be acceptable. If a procedure is selected that is not included in the Plan’s list of covered dental services, the Claims Administrator will select the procedure which is most like the procedure that actually was performed as the basis for reimbursement. Any additional cost for the service that is actually performed will be your responsibility. Such acceptable service or supply must meet the following conditions:

- It must customarily be used nationwide for the treatment;
 - It must be deemed by the dental profession to be appropriate for treatment of the condition; and
 - It must conform with broadly accepted standards of dental practice, taking into account the patient’s oral condition.
- **Rule for Coverage for Dental Work Begun Before You Became Covered by this Plan.** This Plan does not cover work that began before you became covered in this Plan. Accordingly, the following work will not be covered:
 - An appliance, or the modification of an appliance, if an impression for it was made before you became covered by this Plan;
 - A crown, bridge or cast or processed restoration, if a tooth was prepared for it before you became covered by this Plan; or
 - Root canal therapy, if the pulp chamber for it was opened before you became covered by this Plan.
 - **Rule for Coverage for Dental Work Completed After Termination of Coverage.** If dental coverage terminates while you are undergoing treatment, the Plan will not cover treatment that is performed after coverage ends. The exception to this rule will occur if one of the following procedures was ordered while you were covered under the Plan and the service was completed or the supply installed within 30 days of the termination of your coverage.
 - The procedures on which coverage may continue follow:
 - Inlays;
 - Onlays;
 - Crowns;
 - Removable bridges;
 - Cast or processed restorations;

- Dentures;
 - Fixed partial dentures (bridges); and
 - Root canals.
- The meaning of “ordered” as applied in this rule is:
- For a denture: the impressions from which the denture will be made were taken.
 - For a root canal: the pulp chamber was opened.
 - For any other item: the teeth that will serve as retainers or supports, or the teeth that are being restored:
 - > Must have been fully prepared to receive the item; and
 - > Impressions from which the item will be prepared have been taken.

NOTE

If you have additional questions about a service, health care product or expense that may not be covered, call the Plan’s Claims Administrator, Aetna, at the toll-free Member Services number shown on the MILA Resources chart in the Administrative Information section of this SPD.

The MILA Vision Plan

Plan benefits shall be provided through a network of vision care providers as contracted and administered by EyeMed Vision Care. First American Administrators (FAA), a wholly owned subsidiary of EyeMed Vision Care, is the Claims Administrator for the MILA Vision Plan. Benefits shall be available from any vision care provider whose license would permit the provision of the services and supplies. However, if the provider is not in the contracted EyeMed Network, the eligible charge for such service or supply shall be limited to the amount that is specified in the Benefit Summary in Section I, MILA Vision Plan, for the service or supply that would have been covered by the Plan had the service been performed or the supply provided by an EyeMed contracted, network vision care provider who was

qualified to perform the eligible work in the geographic area in which it was performed or supplied.

Vision Care Benefit Payable Under The Plan

The vision care benefits specified in Section I, MILA Vision Plan, will be payable for covered services under the Plan. No other services will be covered.

The EyeMed Network

EyeMed Vision Care’s network of providers includes private practitioners, as well as the nation’s premier retailers, Lens-Crafters®, Target Optical, JC Penney Optical and most Pearle Vision locations. To locate EyeMed Vision Care providers near you, visit www.eyemed.com and choose the Access Network. You may also call EyeMed’s Customer Care Center at **1-866-723-0513**. EyeMed’s Customer Care Center can be reached Monday through Saturday from 7:30 a.m. to 11:00 p.m. EST.

Using In-Network Providers

When you call for an appointment with the provider of your choice, identify yourself as an EyeMed Member; provide your name or Plan number, located on the front of your ID card. Confirm the provider is an In-Network provider for the Access Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed ID card when you visit an EyeMed vision care provider to verify your eligibility.

When you receive services at a participating EyeMed provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable copayments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-Of-Network Providers

If you receive services from an Out-of-Network provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Benefit Summary section. To receive your Out-of-Network reimbursement, complete and sign an Out-of-Network claim form, attach your itemized receipts and send to:

EyeMed Vision Care
 Attn: OON Claims
 P.O. Box 8504
 Mason, OH 45040-7111

REMINDER

You will receive the maximum benefit by using In-Network providers.

NOTE

For your convenience, an EyeMed Out-of-Network claim form is available at www.eyemed.com or by calling EyeMed's Customer Care Center at 1-866-723-0513.

If you elect to use Out-of-Network providers, you will be responsible for paying the Out-of-Network provider in full at the time of service. You may then submit an Out-of-Network claim form for reimbursement. You will be reimbursed up to the amount shown on the Benefit Summary chart.

For prescription contact lenses for only one eye, the Vision Care Plan will pay one-half of the amount payable for contact lenses for both eyes.

Unused benefit allowances for a particular service cannot be used for part of an additional service within the same calendar year.

Additional Discounts

Under the Plan, you may receive benefits for either eyeglasses (frames and lenses) or contact lenses as outlined on the MILA Benefits Summary chart. In addition to this coverage, EyeMed Vision Care provides a discount on products and services once your funded benefit has been used. The discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses);
- 15% off conventional contact lenses; and
- 20% off items not covered by the Plan at network providers.

Discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed provider's professional services, contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount policy.

Discounts may not be available at all participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rates. In

addition, pursuant to Maryland and Texas law, discounts on non-covered services may not be available at all participating providers in these states. Prior to your appointment, please confirm with your provider whether such discounts will be offered.

Laser Vision Correction Procedure

EyeMed Vision Care, in partnership with U.S. Laser Network, offers discounts to you on Lasik or PRK. You will receive a discount (15% off retail or 5% off promotional price) when using a network provider in the U.S. Laser Network. For additional information or to locate a network provider, visit www.eyemedlasik.com or call 1-877-5LASER6.

After you have located a U.S. Laser Network provider, you should contact the provider and identify yourself as an EyeMed Member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at 1-877-5LASER6 to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to U.S. Laser Network. Upon receipt of the deposit, U.S. Laser Network will issue an authorization number to you and to your provider prior to treatment. Once you receive treatment, the deposit will be applied to the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the balance of the fee. Should you decide against the treatment, the deposit will be refunded.

After treatment, you should follow all post-operative instructions carefully. It is your responsibility to schedule any required follow-up visits with the U.S. Laser Network provider to ensure the best results from your laser vision correction procedure.

Mail Order Contact Lens Replacement Program

After initial purchase, you may obtain replacement contact lenses which will be mailed directly to you. For more information, log on to www.eyemedvisioncontacts.com. The contact lens benefit allowance is not applicable to these replacement contact lenses.

Understanding What Is Not Covered

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What Is Not Covered

As you read the following pages, consider what has been said in Section II, Understanding What is Covered. The description of what is covered provides the limits of the coverage as well as providing details of specific descriptions of the coverage. For example, it states that hospitalization is covered but only if that hospitalization provides medically necessary care, the care is not experimental or investigational care as those terms are defined in the Plan, and the hospitalization and the proposed length of stay have been approved in accordance with the terms of the Plan. Also, in describing the scope of the coverage provided, the limits of that coverage are also described.

Accordingly, it is necessary to understand what care and treatment is covered before examining the specific care and treatment which is not covered by the Plan—the subject of this section. Also, the Plan provides no coverage for care or treatment for which you have no responsibility to pay.

Charges Not Covered Under the Medical Plan

While the Plan covers reasonable medical expenses, it does not cover every medical service. Listed below are treatments, procedures and services that are not covered by the Plan as medical care:

- Abortion (elective), unless the physician certifies that the pregnancy would endanger the life of the mother. However, charges arising from medical complications from an abortion are covered;
- Allergy testing by blood, unless direct skin testing cannot be performed or is inconclusive;
- Care not deemed medically necessary (defined on page 26) except for preventive medical treatment if provided by a network provider or for a tubal ligation or a vasectomy;
- Certain military-related services performed in a U.S. government hospital as a result of an illness or injury directly related to military service;
- Charges in excess of reasonable and customary charges (defined on page 27);
- Charges made by a covered provider who is a family member or who normally lives in your home;
- Cosmetic surgery or treatments unless such treatments are:
 - To remedy a condition that is a result of an accidental injury or that is a congenital abnormality that causes a functional defect in a dependent child; or
 - To reconstruct a breast on which a mastectomy has been performed or the other breast to produce symmetry of appearance;
 - If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:
 - > All stages of reconstruction of the breast on which the mastectomy was performed;
 - > Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - > Prostheses; and
 - > Treatment of physical complications of the mastectomy, including lymphedema.
- These benefits are covered by applying the same cost-sharing as is relevant to other medical/surgical benefits.
- If you have any questions about the coverage of mastectomies or reconstructive surgery, please contact Cigna (at the phone number listed on your ID card) or the MILA Plan Office.
- Custodial care which is not intended primarily to treat a covered specific illness or injury, or any care for the purpose of education or training;

- Dental treatment for persons not covered under any dental plan, except for the removal of impacted teeth and treatments for accidental injury to natural teeth;
- Expenses incurred outside the United States unless the participant who is traveling is a resident of the United States who is traveling for pleasure;
- Expenses incurred after coverage ends, even if incurred for a condition existing before coverage ended;
- Experimental medicines or substances not approved by the Food and Drug Administration (FDA) or limited by federal law to investigational use;
- Experimental treatments or procedures not approved by the American Medical Association (AMA) or an appropriate medical specialty society;
- Extraordinary nutrition such as hyperalimentation or Total Parenteral Nutrition (TPN) except for the specific treatment described on page 33;
- Food supplements, except where required to sustain life in the course of tube feeding;
- Eye treatment, including routine examinations and corrective surgery where glasses or contact lenses will provide correction. The Plan will cover a first purchase of eyeglasses or contact lenses after cataract surgery if those supplies are not covered under a vision plan for which you are eligible. In addition, surgical treatments for correction of refractive errors, including radial keratotomy, are excluded;
- Routine use of a hospital emergency room other than for a valid emergency;
- Charges incurred for service as a surrogate for gestational carrier;
- Treatment or surgery, and the associated care and supplies, if such treatment or surgery is not essential for the necessary care and treatment of an illness or injury;
- Charges made by an assistant surgeon in excess of 20% of the surgeon's allowable expense;
- Charges made by an additional surgeon when medically necessary in excess of the surgeon's allowable expense plus 20%;
- Charges for services that would not have been made in the absence of the Plan or for which you are not legally obligated to pay;
- For drugs and medicines not furnished by and administered during confinement as an inpatient in a hospital or provided through the Plan's prescription drug program, unless the Plan's Medical and Prescription Drug Claims Administrators determine that an alternative source for such drugs and medicines provides a safer and more cost effective purchase method;
- Home Health Care
 - Home health care visits during a calendar year, in excess of 120 visits per calendar year;
 - Care or treatment which is not stated in the patient's home health care plan as approved by the Claims Administrator;
 - The services of a person who is a member of your family or your dependent's family or who normally lives in your home or your dependent's home; or
 - A period of care during which a person is not under the continuing care of a physician; and
- Each visit by an employee of a home health care agency will be considered one home health care visit and each four hours of home health aid services will be considered one home health care visit;
- Hospice Care
 - In excess of a lifetime maximum of 180 days;
 - During which you are not under the care of a physician;
 - That is not a part of your hospice care plan as approved by the Claims Administrator;
 - That is not either curative, life prolonging or primarily to aid in daily living; or
 - Bereavement counseling for family members in excess of three sessions per family is not covered.
- Injuries or illness due to acts of war, declared or undeclared;
- Job-related injury or illness covered by Workers' Compensation or any other similar legislation;
- Treatment for an illness or injury caused by a third party, such as an automobile accident, or payable by a third party, such as an insurance company;
- To the extent that benefits are paid or payable under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured

motorist insurance law. The Claims Administrator will take into account any adjustment option chosen by you under such part;

- Ordinary home medical supplies and first-aid items;
- Physical fitness equipment or supplies, athletic training, or general health upkeep or for any treatment or other services related thereto including applied kinesiology, aquatic therapy, dance therapy, movement therapy, Extracorporeal Shock Wave Lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, massage therapy or rolfing;
- Preventive care obtained from an Out-of-Network provider except when covered in the Premier Plan Out-of-Area or in the Medicare Wrap-Around Plan;
- Reversal of sterilization;
- Services that would have been paid first by Medicare for any eligible person who failed to enroll in that program, including a failure to enroll in and pay the premiums for Medicare Part B;
- Services paid for by the U.S. government or a public program other than Medicare or Medicaid;
- Sexual function improvement or restoration, excluding penile implants;
- For or in connection with speech therapy, if such therapy is:
 - Used to improve speech skills that have not fully developed;
 - Can be considered custodial or educational; or
 - Is intended to maintain speech communication (speech therapy which is not restorative in nature will not be covered);
- Television, telephone and other nonessential, non-medical items;
- Testing and storing blood for future use, unless for an operation scheduled within six months;
- Treatment for weight loss, including gastric by-pass and related surgical procedures unless required by an underlying, severe medical condition as determined by the Claims Administrator;
- Treatment or services which have been provided by a licensed provider but which are not within the scope of the provider's license;

- Expenses for reports, evaluations, examinations or hospitalizations which are not required to diagnose or treat an illness or injury. For example, employment physical examinations or insurance examinations are not covered;
- Service and related supplies required to repair or replace an otherwise covered implant are not covered;
- Expenses necessary to perform amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder;
- Expenses for artificial aids to health including but not limited to arch supports, corrective orthopedic shoes, dentures, elastic stockings, garter belts, corsets, and wigs;
- Expenses for the use of ambulance service when such service is not medically necessary or when a lower cost mode of transport would suffice. Air ambulance service will be covered only when the requirement for transport is necessitated by a valid emergency and only this form of transport will accomplish medically necessary delivery of the patient to an adequate treatment setting; and
- Other non-medical services.
- Charges for broken appointment.

NOTE

If you have additional questions about a service, health care product, or expense that may not be covered, call the Plan's Claims Administrator, Cigna, at the toll-free Member Services number shown on the MILA Resources chart in the Administrative Information section on page 95 of this SPD.

Charges Not Covered Under The Behavioral Health Program

Exclusions for expenses incurred in the treatment of mental illness or chemical dependency include all the services, supplies and treatments listed as not being covered in the medical benefits section of this SPD beginning on page 54. In addition, the following expenses incurred in the treatment of mental illness or chemical dependency are not covered under the MILA National Health Plan as behavioral health services:

- Experimental treatments or treatments deemed not medically necessary including, but not limited to, custodial care for chronic conditions, educational rehabilitation or treatment of learning disabilities;
- Illness covered by Workers' Compensation benefits;
- Inappropriate treatment as determined by the Behavioral Health Claims Administrator;
- Services in a government hospital or facility for which no charges are normally made;
- Services, supplies and treatment (including hospitalization) not approved by a physician as necessary for the treatment of your behavioral health condition;
- Services for conditions not attributable to a mental disorder as defined in the current version of the Diagnostic and Statistical Manual (DSM);
- Court-ordered or other externally mandated treatment, unless such treatment is medically necessary;
- Medications or laboratory services not prescribed, dispensed or provided within the protocols established by the Plan's Behavioral Health Claims Administrator;
- Speech therapy except as part of an approved autism therapy plan;
- Educational, employment and custody evaluations;
- Professional training;
- Services provided by self-help groups;
- Behavioral dysfunctions that result primarily from organic conditions (e.g., organic brain syndrome, Alzheimer's and mental retardation), except for acute interventions for stabilization of psychiatric conditions and for treatment of autism under an approved autism therapy plan;
- Marriage or stress counseling, except when rendered in connection with treatment of a DSM mental disorder;
- Services that would have been paid first by Medicare for any eligible person who failed to enroll in that program, including a failure to enroll in and pay the premiums for Medicare Part B;
- Behavioral treatment that is not medically necessary;
- Treatment for smoking cessation, weight reduction, obesity, stammering and stuttering;
- Treatment for codependency, except when rendered in connection with treatment of a DSM mental disorder;

- Non-abstinence based and nutritionally based chemical dependency treatment except when medically necessary;
- Treatment for sexual addiction, except when rendered in connection with treatment of a DSM mental disorder;
- Treatment of chronic pain, except when rendered in connection with treatment of a DSM mental disorder;
- Treatment or consultations provided by your parents, siblings, children, spouse, former spouse or domestic partner; and
- Ambulance services or other transportation, except when medically necessary and pre-approved by the Plan's Behavioral Health Claims Administrator. However, pre-approval is not necessary in the case of an emergency.

NOTE

If you have questions about the mental health and substance abuse benefits or required approvals, or to determine if a particular expense is covered, you can call Cigna directly at the toll-free number shown on the MILA Resources chart in the Administrative Information section of this SPD or on the back of your ID card.

Charges Not Covered Under The Prescription Drug Program

Listed below are medications the MILA National Health Plan does not cover under the Prescription Drug Program:

- Drugs that do not require prescriptions, also referred to as "non-legend" or "over-the-counter" drugs, except those for the treatment of diabetes, even if a prescription is presented;
- Drugs for the treatment of pain (delivered as patches, lotions or creams), the active ingredients of which are sold over the counter but one or more of the active ingredients are in an increased concentration;
- Compound prescriptions that do not have at least one ingredient that is a legend drug requiring a prescription under federal or state law or for which you have not received prior authorization from the Claims Administrator pursuant to the Plan's requirements;

- Drugs not included in the MILA/CVS Caremark Prescription Drug Formulary;
- Drugs that are covered under another part of the MILA National Health Plan or that are limited or excluded because they are experimental, investigational or not medically necessary;
- Drugs that are covered under Workers' Compensation or any government program (state, federal or municipal) that does not claim secondary payer status;
- Drugs or devices for cosmetic purposes, hair growth, smoking cessation, anti-obesity, weight control, and contraception except for oral contraceptives and the specific products NuvaRing and Ortho Evra;
- Drugs not approved by the U.S. Food and Drug Administration (FDA) or not approved by the FDA for the condition, dose, routine and frequency for which they are being prescribed;
- Drugs provided at no charge to you or for which you would not have to pay in the absence of this or similar coverage;
- Drugs required as a result of an act of war, declared or undeclared;
- Food, diet and nutritional supplements except prescription vitamins and minerals; and
- Natural remedies (naturopathic) and homeopathic services, substances and supplies.

NOTE

If you have questions about the Prescription Drug Program or to determine if a particular prescription drug is covered, you can call CVS Caremark directly at **1-866-875-MILA (6452)**.

Charges And Services Not Covered Under The Dental Plan

The following dental services or supplies are not covered under the MILA National Health Plan.

- Services or supplies for treatment before your coverage under the Plan begin;
- Services not performed by a dentist, except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for:
 - Scaling and polishing of teeth; or
 - Fluoride treatments.
- Cosmetic surgery or supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services or supplies which improve or alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the list of covered dental services on pages 46-48. Facings on molar crowns and pontics will always be considered cosmetic. However, any cosmetic surgery or supply will be covered if:
 - It otherwise would be a covered expense; and
 - It is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or
 - It is required for reconstructive surgery because of a congenital disease or anomaly of a covered child which has resulted in a functional defect.
- Replacement of lost, missing or stolen crown, bridge or denture;
- Services or supplies which are covered by any Workers' Compensation laws or occupational disease laws;
- Services or supplies which are covered by any employers' liability laws;
- Services or supplies which any employer is required by law to furnish in whole or in part;
- Services or supplies which are received through a medical department or similar facility which is maintained by the covered person's employer;

- Services or supplies which are received by you for which no charge would have been made in the absence of this Plan's coverage;
- Services or supplies for which you are not required to pay;
- Services or supplies which are deemed experimental in terms of generally-accepted dental standards;
- Services or supplies which are received as a result of dental disease, defect or injury due to an act of war, or war-like act in time of peace which occurs while your coverage under the Plan is in effect;
- Adjustment of a denture or bridgework which is made within six months after installation by the same dentist who installed it;
- Dental braces, mouthguards and other devices to protect, replace or reposition teeth except for space maintainers for children and children's orthodontic appliances;
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply;
- Any duplicate appliance or prosthetic device;
- Use of material or of home health aides to prevent decay, such as toothpaste or fluoride gels other than the topical application of fluoride;
- Instruction for oral care such as oral hygiene, plaque control or diet;
- Dentures, crowns, inlays, onlays, bridges or other appliances or services used for the purpose of splinting or to alter the vertical dimension, to restore occlusion or correcting attrition or erosion except as specifically provided in the list of covered dental services on pages 46-48;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Services or supplies to the extent that benefits are otherwise provided under this Plan, under any other MILA Plan, or under any other plan, to which your employer (or an affiliate) contributes or sponsors and from which you are eligible to receive benefits;
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night

guards, except as specifically provided in the list of covered services on pages 46-48;

- Charges for broken appointments;
- Charges by the dentist for completing dental forms or submitting dental claims;
- Sterilization supplies;
- Services or supplies furnished by a family member;
- Treatment of any jaw joint disorder and any treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorders (TMJ), orthognathic surgery and treatment of malocclusion or devices to alter bite or alignment, except as specifically provided in the list of covered services on pages 46-48; and
- Orthodontia for adults when not medically necessary.

Charges And Services Not Covered Under The Vision Plan

The following vision services and supplies are not covered under the MILA National Health Plan:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
- Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Corrective eyewear required by an employer as a condition of employment and safety eyewear;
- Services provided as a result of any Workers' Compensation law;
- Plano (non-prescription) lenses and non-prescription sunglasses (except for 20% discount);
- Two pairs of glasses in lieu of bifocals;
- Services or materials provided by any other group benefit plan providing vision care;
- Services rendered after the date a patient ceases to be covered under the Plan, except when vision materials ordered before coverage ended are delivered, and the services rendered to the patient are within 31 days from the date of such order;

- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next calendar year when vision materials would next become available;
- Discounts on frames where the manufacturer prohibits discounts, including, but not limited to the following manufacturers: Bvlgari, Cartier, Chanel, Gold & Wood, Maui Jim and Pro Design;
- Applicable taxes; and
- Visual Display Terminal (VDT) Exam.

Coordination Of Benefits

If you have coverage under another plan, the MILA National Health Plan will coordinate payment of benefits with that other coverage. This process prevents duplicate payments for the same medical expenses and determines which plan pays benefits first. If you are eligible for MILA National Health Plan benefits as an employee or pensioner and your spouse is also eligible for MILA National Health Plan benefits as an employee or pensioner, please refer to “Which Plan Pays Benefits First” below for details about the coordination of your benefits. The Vision Plan through EyeMed does not contain a coordination-of-benefits provision.

How Coordination Works

Benefits are coordinated based on which plan is primary and which plan is secondary. The primary plan pays benefits first. Generally, the plan providing secondary coverage makes payment on the remaining balance, which may further reduce or eliminate your out-of-pocket expense. When benefits are coordinated, the total amount paid by both plans will never be more than 100% of the total allowable or covered expense under the MILA Plan.

Coordination of benefits applies to any group insurance or other group coverage and coverage under a government program, such as Medicare.

Which Plan Pays Benefits First

If your other plan does not coordinate benefits, it is automatically considered the primary plan for coverage, and it is required to pay benefits first. If both plans coordinate benefits, these guidelines apply:

- The health plan covering you directly is the primary plan and pays first, and the other plan is secondary. For example, coverage under this Plan is primary for you but secondary for your spouse if your spouse has coverage through your spouse’s employer. If both the husband and the wife are covered in MILA, the husband’s coverage is primary for him and secondary for his wife and the wife’s coverage is primary for her and secondary for her husband;
- If a dependent child lives with both parents and the child is covered by both parents’ plans, the plan of the parent whose birthday falls earlier in the calendar year pays benefits first for that child. If both parents have the same birthday, the plan that has covered one of the parents longer pays first. If one parent’s plan does not recognize these “birthday” coordination rules, the father’s plan pays first;
- In a case of divorce or separation, the plan of the parent who has court-ordered financial responsibility for the dependent child pays first. If there is no court order, the plan of the parent with actual custody, whether or not your spouse remarries, pays first. For court-ordered joint custody, the birthday rules described above apply;
- If a court decree gives financial responsibility of a dependent child to one parent, then that parent’s plan pays first;
- If none of the preceding rules apply:
 - The primary plan is the one covering you for the longest period of time, and pays first; or
 - The health plan covering you because of active employment pays before any plan covering you as a pensioner or as a participant under COBRA continuation coverage.

If You Are Overpaid Benefits

If by chance the Plan makes benefit payments on allowable expenses that are more than 100% of the maximum benefit payment, the Plan reserves the right to recover the amount of the overpayment from individuals, insurance companies or any other Claims Administrators. If any overpayment is not returned, MILA has the right to cancel your coverage and begin legal action to recover the overpayment. See “Third-Party Reimbursement and Subrogation.”

If a benefit payment exceeds the benefit amount that you are entitled to receive, the Plan has the right to (1) require the return of the overpayment, (2) reduce by the amount of the

overpayment any future benefit payment made to or on behalf of any participant in the Plan, and (3) reduce future payments to the provider that received the overpayment by the amount of the overpayment. The reduction of future payments to a provider may involve the Plan or other plans that are administered by the same claims administrator. Under this process, the Plan's Claims Administrator would reduce future payments to a provider by the amount of the overpayment that the provider received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under the Plan are subject to this same process when the Plan's Claims Administrator recovers overpayments for other plans administered by that same claims administrator. This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Failure to reimburse the Plan for such overpayment within four weeks from the date of the demand by the Plan for repayment of the overpayment may in the MILA Trustees' discretion disqualify you and your dependents from receiving any future benefits under the Plan, and may result in the pursuit of legal action by the Plan to recover the overpayment.

Third-Party Reimbursement And Subrogation

Plan Benefits Are Subject To Subrogation And Reimbursement

The Plan may advance benefits to or on behalf of you or your dependent if you or your dependent is injured or becomes ill as the result of an act or omission of a third party. The Plan, by providing benefits to you or your dependent, is hereby granted an automatic lien on the proceeds of any settlement, judgment, or other payment intended for, payable to, or received by you or your dependent or your or your dependent's attorney, representative, or any other party.

If the Plan advances medical benefits, it has a right to subrogation and reimbursement to the full extent of all payments made by the Plan. The Plan's right to subrogation and reimbursement provides the Plan with a priority over any funds received by you or your dependent from any third party (including but not limited to a negligent third party or an insurance company) when such funds are paid because of or the payment relates to the act or omission of the third party.

The Plan's right to subrogation and reimbursement shall not be defeated or reduced by the application of any so-called "Make Whole Doctrine," "Rimes Doctrine," "Fund Doctrine,"

"Common Fund Doctrine," "Attorney's Fund Doctrine" or any other doctrine, theory or state law purporting to defeat the Plan's right to a full recovery, including any doctrine, theory or state law purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively or primarily to damages for nonmedical expenses.

The Plan's right to subrogation and reimbursement of full payments made by the Plan shall not be defeated or reduced by any claim of fault on the part of you or your dependent, whether under comparative negligence or any other doctrine, theory or state law.

Subrogation And Reimbursement Rights Are Primary

The Plan's right to subrogation and reimbursement is primary and shall come before any and all rights to any recovery held by you or your dependent or your or your dependent's attorney, representative or any other party. The Plan's right to subrogation and reimbursement exists regardless of the manner in which the payment to you or your dependent or your or your dependent's attorney, representative or any other party is designated or whether the amount is received by you or your dependent or your or your dependent's attorney, representative, or any other party.

Acceptance Of Plan Benefits Constitutes Acceptance Of Subrogation And Reimbursement Obligation

By accepting the benefits under the Plan, you or your dependent or your or your dependent's attorney, representative, or any other party, agree to hold the proceeds of any settlement, judgment or other payment in trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of you or your dependent.

You or your dependent further agree to assign to the Plan an amount equal to the benefits paid against any recovery made by or on behalf of you or your dependent. This assignment is binding on any attorney who represents you or your dependent, whether or not an agent of your or your dependent, and any insurance company or other financially responsible party against whom you or your dependent may have a claim. You or your dependent agree that a breach of your or your dependent's obligations under this section of the MILA SPD or Article 9 of the MILA Plan would cause irreparable and substantial harm to the Plan.

The Plan may at any time request a separate recovery authorization or lien form signed by you or your dependent or your or your dependent's attorney, representative or any other party,

which acknowledges your or your dependent's obligation to repay the Plan for benefits advanced or to be advanced by the Plan to or on behalf of you or your dependent. The Plan may require you or your dependent to complete such a separate recovery authorization or lien form as a condition to the Plan's making payments to or on behalf of you or your dependent.

The Plan may also require your or your dependent's attorney to execute the recovery authorization or lien form acknowledging the attorney's obligation to act in accordance with, and the attorney's agreement to be bound by, the terms of this Plan and the attorney shall not be entitled to receive any attorney fees through the Fund or a cut of the Plan's recovery.

Requirement To Cooperate With The Plan

You or your dependent must cooperate with the Plan, provide all information requested by the Plan, assign to the Plan any money received arising out of or relating to the act or omission of the third party, and must take any further actions the Plan may reasonably require to fully effectuate the terms of this Plan and facilitate enforcement of the Plan's rights. You or your dependent must not do anything to prejudice or interfere with the rights and interests of the Plan. If you or your dependent fail to respond to any request for information sent to you or your dependent by the Plan or any entity acting on behalf of the Plan, your and your dependents' benefits will be suspended on whatever terms and conditions the MILA Trustees deem appropriate. Your or your dependent's attorney or other representative agrees to comply with your or your dependent's obligation to cooperate with the Plan.

Notice Requirements

You or your dependent must notify the Plan within 30 days of any injury or illness that is the result of an act or omission of a third party. Thereafter, you or your dependent must immediately notify the Plan when you or your dependent retains an attorney in contemplation of an action against a third party because of illness or injury, commences an action (including arbitration or mediation) against a third party, engages in settlement discussions, enters into a settlement agreement, obtains a judgment, receives monies as the result of a settlement or judgment, or takes any other action which may affect the Plan's right to recover the monies it has advanced to you or your dependent. Any monies received by you or your dependent or your or your dependent's attorney, representative or any other party as the result of a settlement or judgment, if not conveyed directly to the Plan, must be immediately placed into a trust account and shall not be withdrawn or transferred until the Plan has received payment in full.

No Pro-Rata Distribution

There shall be no pro-rata distribution of any recovery between you or your dependent and the Plan. The Plan shall not be responsible for any of your or your dependent's attorney's fees or costs of litigation. The Common Fund doctrine shall not apply.

No Expenses On Behalf Of The Plan

Neither you nor your dependent shall incur any expenses on behalf of the Plan in pursuit of the Plan's right to recovery. Specifically, no court costs or attorneys' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," or "Attorney's Fund Doctrine."

The Plan's Right Of Recovery

The Plan's subrogation and reimbursement rights and liens apply to any recoveries obtained by you or your dependent as a result of the injuries sustained, including but not limited to the following:

- (a) any payments made by or on behalf of a third-party tortfeasor, including an insurance company;
- (b) any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured- or underinsured-motorist coverage, whether on behalf of you or your dependent or other person;
- (c) any other payments from any source designed or intended to compensate you or your dependent for injuries sustained as a result of the act or omission of a third party;
- (d) any worker's compensation award or settlement;
- (e) any recovery made pursuant to no-fault insurance; and
- (f) any medical payments made as a result of such coverage in any automobile- or homeowners-insurance policy.

No Assignment, Reductions, or Exclusions

Neither you nor your dependent may assign any right that you or your dependent may have to recover medical expenses from any tortfeasor, individual, or other person or entity to any individual other than you or your dependent without the prior express written consent of the Plan. Additionally, neither you nor your dependent shall make any settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.

The Plan's Right To Suspend Benefits

If you or your dependent receive any money either directly or in trust for the benefit of you or your dependent, from a third party by settlement, whether there is a no-liability stipulation clause or not, judgment, insurance proceeds or otherwise, arising out of or related to the act or omission of a third party, the Plan is entitled to receive such payment up to an amount equal to the amount paid by the Plan. If you or your dependent do not pay the Plan, the Plan may suspend your and your dependents' Plan benefits on whatever terms and conditions the MILA Trustees deem appropriate.

Subrogation

Subrogation empowers the Plan to act on behalf of you or your dependent, and thus to enforce your or your dependent's rights and remedies against third parties through litigation.

Third-Party Payments Due To The Plan First

You or your dependent must assign and agree to subrogate the Plan to the full extent of all payments made by the Plan and all rights, claims and interests which you or your dependent has or may have against any third party to enforce the Plan's claim.

The Plan's Subrogation Rights Are Not Contingent Upon Other Acts

The Plan's right to subrogation is not contingent upon your or your dependent's obtaining a settlement, judgment, insurance proceeds or other payment that fully compensates you or your dependent for the total losses you or your dependent sustained. Your or your dependent's right to be made whole is superseded by the Plan's right to subrogation.

Reimbursement

Reimbursement affords the Plan a direct right of recovery against you or your dependent.

Requirement To Reimburse Plan

As a condition to and in consideration of coverage under the Plan, you or your dependent agree to fully reimburse the Plan to the complete extent of any recovery received from or on behalf of a third party arising out of or relating to the act or omission of the third party.

The Plan's Right Of Recovery

If benefits are paid by the Plan and you or your dependent recover from a third party by settlement, judgment, insurance proceeds or otherwise, the Plan has the right to recover from

you or your dependent an amount equal to the amount paid by the Plan. Your or your dependent's right to be made whole is superseded by the Plan's right to reimbursement.

The Plan's Right To Attorneys' Fees And Costs

In the event that you or your dependent or your or your dependent's attorney, representative, or other party fails or refuses to honor your or your dependent's obligations in connection with the Plan's right to subrogation and reimbursement. The Plan shall be entitled to recover any costs incurred in enforcing the terms of the Plan, including but not limited to attorneys' fees, litigation costs, court costs and other expenses.

The Plan's Right To Receive And Release Information

The Plan may, without the consent of you or your dependent or your or your dependent's attorney, representative, or other party, obtain information from and release information to any attorney, insurance carrier, physician, medically related facility, employer, or other party in order to facilitate the Plan's rights of subrogation and reimbursement. You or your dependent and your or your dependent's representative must provide to the Plan any and all individually identifiable health and medical information, records, and reports requested by or on behalf of the Plan in order to facilitate the Plan's rights of subrogation and reimbursement.

Rescission Of Coverage

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

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

The coverage for you or your dependent(s) may also be terminated retroactively (without notice) due to a failure to timely pay any premiums or self-pay contributions, including COBRA

premiums. This means that the Plan may retroactively terminate coverage without notice in the event of a legal separation/divorce or a child's ceasing to meet the definition of child.

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

Waiver of Benefits

If you waive MILA coverage (or any portion thereof) for yourself, then you will also be waiving coverage for any eligible dependent who otherwise might have been eligible to participate. Alternatively, you may waive coverage only on your eligible dependents (spouse and/or children).

The waiver may be revoked and full coverage restored: (1) on the date the other coverage is lost, (2) the date a qualified life event occurs or (3) annually on January 1st, provided MILA is notified in writing within the required time. You must notify the Plan within 31 days of the date of such coverage termination or qualified life event or by December 1st prior to the desired reenrollment on January 1st of your desire to reenroll. In addition, the circumstances justifying such reenrollment must be explained in the case of a qualifying life event or a termination of the alternate coverage. MILA will notify you if reenrollment has been accomplished on the date for which it was applied or, if the reenrollment has been rejected, the reasons for that rejection.

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As described in the section entitled, **When You Become Covered Under the Plan**, your eligibility as an active Member of one of the three available plans depends on the number of credited hours that you receive during the prior contract year. Your eligibility for coverage as a pensioner depends upon your length of service in the industry when you retire, your age at retirement, the type of retirement you elect, and your eligibility to enroll in Medicare.

Who Is Eligible

You will be eligible to participate in the MILA National Health Plan if:

- You are an active bargaining-unit Member who has earned the specified number of credited hours listed below in the prior contract year;

MILA Premier Plan	MILA Basic Plan	MILA Core Plan
1,300 Hours or more	1,000 to 1,299 Hours	700 to 999 Hours

- You are a pensioner who retired from active work in the industry and immediately began receiving a pension based on years of service as a bargaining-unit member. You must have attained the minimum age required for welfare plan coverage and you must have been credited with the years of service specified in the chart below:

MILA Premier Plan	MILA Basic Plan	MILA Medicare Wrap-Around Plan
Age 62 with 25 or more years of credited service	Age 58 with 25 or more years of credited service	Age 65 with the number of years of credited service required by your local Port

- You are a pensioner who is receiving a disability pension from your local Port under the rules in effect on September 30, 1996.

You will qualify for MILA benefits if (1) you present proof to MILA that you have applied to the Social Security Administration for Social Security Disability Income (SSDI) Benefits or, if qualified, for regular unreduced Social Security Income Benefits and (2) you have been

determined to be permanently disabled for purposes of performing longshore work by an independent medical examiner appointed by MILA. If that independent medical examiner determines that you are not permanently disabled for purposes of performing longshore work, you may seek a determination from MILA's Board of Trustees. If the Board of Trustees determines that you are not permanently disabled for purposes of performing longshore work, you will no longer be eligible for MILA benefits.

- You are the surviving spouse of an active longshore employee, you and your eligible children will receive the MILA benefits that your spouse was receiving at the time of death, provided that at the time of your spouse's death, your spouse:
 - Was working on a job for which the \$5.00 man-hour contribution was paid to MILA; and
 - Was receiving MILA benefits; and
 - Would have been eligible for a disability pension based upon your spouse's age and years of service in your spouse's local Port.

On the first day of the following calendar year you and your children who continue to be eligible for coverage by the Plan shall begin receiving the better of (a) the Plan benefits that your spouse was receiving at the time of death, and (b) the Plan benefits your spouse earned through the date of death.

If your spouse's local Port has discontinued disability pensions, you and your eligible children will be entitled to Plan benefits if at the time of your spouse's death, your spouse would have qualified for a disability pension under the rules in the Port which were in effect before the Port discontinued disability pensions. You and your eligible children will receive benefits pursuant to the eligibility rules contained in the MILA Plan.

- You are the surviving spouse of a pensioner, you will qualify for health care benefits based upon the rules of the relevant local Port that were in effect as of October 1, 2004. If you are not eligible for benefits under the rules in effect on October 1, 2004, then, effective May 1, 2008, you will qualify for benefits if you are the surviving spouse of a pensioner who died on or after May 1, 2008, with 25 or more years of credited service. If your spouse had not reached age 58 when your spouse died, you and your eligible children will commence receiving MILA Basic plan benefits when your spouse would have attained age 58.
- Certain other former bargaining-unit Members, non-bargaining unit Members, and Members of other

organizations recognized by MILA's Board of Trustees may also be eligible to participate in the Plan.

Your Eligible Dependents

Children are eligible until the end of the month in which they attain age 26. Your dependents may also be eligible to participate. For Plan purposes, your eligible dependents are:

- Your spouse, if you are legally married under the laws of the state in which you were married. A spouse is no longer covered on the date of divorce:
- Your children, whether natural-born, adopted, stepchildren through a current legal marriage or other children under your legal guardianship or who are covered under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).
- A child for whom legal guardianship, legal custody, or similar legal relationship arising under state law, such as conservatorship, has been awarded to you may be covered as a dependent child, provided that (1) the child is listed as a dependent on your federal income tax return, (2) a copy your federal income tax return is provided to MILA each year for which coverage for the child is requested, and (3) your guardianship, custody, or other similar legal relationship over the child is not shared with the child's natural parent(s). When all of the above conditions have been satisfied, coverage will be provided to the child even though the natural parent(s) has been granted visitation rights or parenting time.

MILA reserves the right to request at any time a copy of your federal income tax return to ensure that the child is claimed as a dependent. If you fail to provide a copy of your federal income tax return upon MILA's request, MILA may terminate the child's coverage.

The child of a pensioner will be eligible only if the child was covered under the Plan or a predecessor plan on the pensioner's retirement date or was born to the pensioner after the pensioner retired.

Your unmarried child of any age who is incapacitated and, as a result, is incapable of self support due to a mental or physical disability and who is primarily dependent on you for support and maintenance, provided the incapacity began before the child reached age 26. The child will remain eligible for as long as the child remains continuously incapacitated and dependent upon you for federal income tax purposes.

The Plan may periodically require you to supply written proof of the child's mental or physical incapacity and continued dependence. The Plan also has the right to request at its expense an independent medical, psychiatric or psychological examination of the child; and your parents who qualify for coverage as "collateral dependents" if they were covered as collateral dependents under a local Port Plan as of December 31, 1999. Coverage will end for each collateral dependent on the first of the following:

- On the last day of the month in which you marry or have an eligible dependent child; or
- On the last day of the first calendar year in which the collateral dependent can no longer be claimed as a dependent on your federal income tax return; or
- On the last day that collateral dependents could have been covered under the rules in effect in your local Port on September 30, 1996.

NOTE

Coverage for your eligible dependents starts when your coverage does or when they first become eligible to participate under the terms of the Plan. For example, if you get married while you are covered under the Plan, your spouse's coverage could start on the date you marry. However, you must enroll your new spouse with your local Port Administrator or with MILA within 31 days of the date of your marriage. Otherwise, coverage will not begin until you enroll your spouse.

Enrollment And Proof Of Dependent Status

If you wish to cover your eligible dependents (spouse or children), you must provide with your enrollment form documentation verifying the eligibility of your dependents before your dependents will be enrolled in coverage. A list of appropriate documentation which may establish eligibility by dependent category is listed below:

For You

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

For Your Spouse

- A copy of your spouse's Social Security Card
- A copy of your spouse's birth certificate
- A copy of your spouse's Medicare Card, if applicable
- Information concerning other insurance coverage (for example, Blue Cross/Blue Shield, Horizon Blue, etc.)
- A copy of your marriage certificate
 - In the case of a marriage in which a marriage certificate has been issued by a competent jurisdiction, a copy of that marriage certificate must be sent to MILA within 31 days of marriage.
 - In the case of "common law" marriage in states which recognize such marriage: An affidavit attesting that (1) the two persons have met each of the standards which the state requires to qualify and (2) the two persons affirm that they are married.
 - Copies of the federal income-tax return following satisfaction of the state's common law standard evidencing a marriage.
 - In the case of divorce, a copy of the final decree of divorce.

For Each Child

- A copy of each child's Social Security Card
- A copy of each child's birth certificate (parents' names must be listed)
- A copy of the Medicare Card for a disabled child or a child with renal failure, if applicable
- Proof of each child's relationship to you:
 - In the case of a natural child or stepchild, a copy of the birth certificate in which you or your spouse is listed as a parent.

- In the case of an adopted child, a copy of the adoption agreement or, if the child was placed for adoption before the final adoption proceedings, a copy of the placement order from a court of competent jurisdiction. In the latter case, when final adoption occurs, a copy of this documentation also should be forwarded to MILA.
- If you have been awarded Legal Guardianship or Legal Custody of a child, a copy of the court order or other legal order from an agency or court with jurisdiction granting the guardianship or custody and a copy of your federal-income-tax return listing the child as your dependent. A copy of your federal income-tax return must be provided to MILA each year to maintain coverage for the child.
- For an eligible disabled child who was a covered person under this Plan or a predecessor plan who has attained the age of 26:
 - Proof (federal income-tax returns) that the child is dependent on you for support and maintenance;
 - Proof that the child is incapacitated. This means that the child meets the following conditions:
 - > A dependent is incapable of self-sustaining employment by reason of a mental or physical disability that began prior to the attainment of age 26.
 - > Statements from a physician qualified to assess the child's condition should be obtained for the initial determination and periodically thereafter. All such statements should go to MILA.
- If applicable, a copy of a Qualified Medical Child Support Order (QMCSO) from a court of competent jurisdiction or a National Medical Support Notice (NMSN) issued by a state agency or a court of competent jurisdiction that requires that coverage be provided.

Special Enrollment

If you have new dependents as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your

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

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

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

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

Obtaining Coverage After Having Previously Declined MILA Coverage

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

When you or your dependents lose eligibility for that other coverage, you must request enrollment in the Plan within 60 days after that other coverage ends (or after the employer stops contributing toward the other coverage). You will be required

to provide proof of loss of the other group coverage.

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

Rescission Of Coverage

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

Failure to inform any persons that you or your dependents are covered under another health plan or knowingly withholding or providing false information in order to obtain (or continue) coverage for yourself and your eligible dependents are examples of actions that constitute fraud under the Plan.

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

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

Your Dependent May Be Eligible Pursuant To A Qualified Medical Child Support Order (QMCSO) Or A National Medical Support Notice (NMSN)

A child who does not meet the Plan's eligibility requirements based upon the child's relationship to you or your spouse may still qualify for coverage under the Plan if the right to coverage is provided in a QMCSO or in a properly completed NMSN and the child remains within the limiting age or qualifies as incapacitated. A QMCSO is a medical child support order that creates or recognizes the right of an "alternate recipient" to receive benefits for which a participant or beneficiary is eligible under a group health plan and the group health plan recognizes the order as "qualified" because it contains necessary information and meets other requirements which are necessary to qualify as a QMCSO.

A QMCSO is a judgment, decree or order (including an approval of a property settlement) that:

- Is made pursuant to state domestic relations law (including community property law) or certain other state laws relating to medical child support; and
- Provides for child support or health benefit coverage for a child of a participant under a group health plan and relates to benefits under that plan.

A NMSN is a medical support order issued by state child support agencies. The notice is used by the agencies to enforce child support obligations, and requires dependent children to be covered under the health plan of the named parent

The following information must be supplied to the Plan in order for the Plan to consider the order "qualified":

- The name and last known mailing address of the participant and each alternate recipient, except that the order may substitute the name and mailing address of a state or local official for the mailing address of the alternate recipient;
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined) and;
- The period to which the order applies.

An order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the

plan, except to the extent necessary to meet the requirements of certain state laws.

A QMCSO or a NMSN should be sent to the Plan for review of its qualified status. The Plan will act expeditiously and will respond to the participant and any required third parties regarding the status of the order and the coverage for the alternate recipients.

When You Become Covered Under The Plan

The number of credited hours required for coverage under the three benefit Plans are as follows:

Credited Hour Requirements	
Premier Plan	1,300 or More Hours
Basic Plan	1,000–1,299 Hours
Core Plan	700–999 Hours

A contract year begins on October 1st and ends on September 30th. For example, if you received 1,250 credited hours during the contract year, you would be covered by the Basic Plan in the following calendar year. However, if you received 1,300 or more credited hours during the contract year, you would be covered by the Premier Plan.

Affordable Care Act (ACA) Notice— The 90-Day Rule And The 13-Month Rule

If you were not eligible for Plan benefits beginning in a calendar year but you qualify for MILA coverage during the subsequent calendar year based upon credited hours earned during the contract year, you will be subject to ACA rules as to when your coverage will begin. Your coverage will begin on the earlier of (1) the beginning of the month that is 13 months from the month in which you earned your first credited hour during the contract year and (2) 90 days from the end of the contract year. For example:

- If you earned your first credited hour during October 2019 and earned at least 700 credited hours during the contract year ending September 30, 2020, your coverage would begin on November 1, 2020 (13-Month Rule);
- If you earned your first credited hour during November 2019 and earned at least 700 credited hours during the contract year ending September 30, 2020, your coverage would begin on December 1, 2020 (13-Month Rule); and

- If you earned your first credited hour during December 2019 or later and earned at least 700 credited hours during the contract year ending September 30, 2020, your coverage would begin on December 29, 2020 (90-Day Rule).
- If you were covered by the Plan during 2019 and earned at least 700 credited hours during the contract year ending September 30, 2019, you would not be affected by the ACA rules. The benefit plan in which you would be covered beginning January 1, 2020, would be determined by the total number of credited hours earned during the contract year ending September 30, 2019, as it had been before the ACA rules.

Contributions Of Less Than \$5.00 Per Hour

If the man-hour contribution rate in a local collective bargaining agreement is lower than the \$5.00 per man-hour rate required to be paid to MILA in the Master Contract, the number of hours worked which are required to receive one credited hour will be proportionately higher, based on the level of contributions actually made to MILA. For example, if you worked in covered employment where your employer was required to contribute \$2.50 per hour to MILA when the Master Contract rate was \$5.00, you would receive one credited hour for each two hours of work.

Non-Bargaining Unit Members

You will be covered in your employer's benefit plan on the first day of the month after you complete the appropriate period of service or employment needed to become eligible for benefits as determined by your employer. In addition, you will be informed of the benefit plan under which you will be covered; this benefit plan coverage has been determined by your employer and approved by the MILA Trustees for all similarly situated employees. Your dependents also will be covered provided that you enroll each dependent within 31 days of the date your coverage begins; otherwise, dependent coverage for each person not enrolled will be deferred until the date on which the dependent is actually enrolled. In order for coverage to begin, the MILA Trustees must have accepted your employer for coverage under the MILA National Health Plan and your employer must have agreed to participate in the Plan and to contribute an amount that will cover the expected cost of your benefits as established by the MILA Trustees for that year.

Effective January 1, 2019, if you are receiving benefits under a participation agreement between your employer and MILA and are not eligible for any other survivor health insurance

benefits and die while actively employed by that employer, your surviving spouse, and dependent children will receive the MILA Benefit Plan benefits which you were receiving at the time of your death, provided that at the time of your death (1) you were receiving MILA benefits; (2) your employer had paid all contributions under the participation agreement through the date of your death; and (3) you had at least 15 consecutive years of service in the industry. Years of service in the industry shall include:

- a) any employment for which contributions were made or are being made under a participation agreement by (1) any ILA Local or District that represents longshore employees working at ports on the Atlantic and Gulf Coasts of the United States; (2) any employer who employs longshore employees working at ports on the Atlantic and Gulf Coasts of the United States; (3) any multiemployer association that represents employers who are parties to a longshore contract covering longshore employees working at ports on the Atlantic and Gulf Coasts of the United States, and (4) any local port benefit plan that has a participation agreement with MILA, and
- b) any employment by (1) any company that was a signatory to a deepsea collective bargaining agreement covering ports in the United States, except Alaska and Hawaii, and (2) any company bound by the terms of any deepsea collective bargaining agreement covering ports in the United States, except Alaska and Hawaii, with a multiemployer bargaining association by reason of being a member of such association.

Your surviving spouse and dependent children will receive benefits under this provision until your surviving spouse becomes Medicare eligible when your surviving spouse will receive MILA Medicare Wrap-Around benefits. Your dependent children will receive benefits pursuant to the MILA eligibility provisions for children until they no longer qualify as dependents as defined in the Plan. If at the time of your death you were not eligible for MILA retiree benefits, your surviving spouse will receive benefits until your surviving spouse becomes Medicare eligible, at which time your surviving spouse will no longer receive benefits from MILA. Your children will receive benefits pursuant to the MILA eligibility provisions for children until they no longer qualify as dependents as defined in the Plan. If your employer ceases to be covered by a participation agreement, the benefits for your surviving spouse and dependent children will be discontinued 90 days after the employer stops covering its employees under a participation agreement.

NOTE

All MILA's Claims Administrators are reviewing the need for ID cards. In part, this is due to the fact that the provider is supposed to confirm coverage when the patient arrives for service. For this reason, over the next several years each Claims Administrator may eliminate the requirement for an ID card.

Coverage Will End For...	At This Time...
You, your spouse and dependent children	On the last day of the calendar year following the end of a contract year in which you fail to receive credited hours* sufficient to qualify for a MILA benefit.
You	On the date you enter active duty U.S. military service for 31 days or more. However, your spouse and children will continue to be covered during the initial period of your tour of duty or the period your credited hours qualify for coverage, if longer.
Your spouse and dependent children	If your spouse and children are covered because of your active duty military service, the end of the month in which you re-enlist, extend your active duty military service, or extend your reserve status.
Your spouse and dependent children	If you die, on the last day of the calendar year for which you earned coverage unless your spouse and children are eligible for benefits because your spouse is an eligible surviving spouse under the MILA Plan.
You, your spouse and dependent children	On the date following your retirement on which your active coverage would end, unless you satisfied the requirements for coverage as a pensioner under the MILA Plan.
You, your spouse and dependent children	If you are a non-bargaining unit Member and are not otherwise eligible for coverage, on the last day of the month in which your employment ends with your current employer.
You, your spouse and dependent children	On the date the Trustees or the parties to the Master Contract terminate this Plan.
You, your spouse and dependent children	On the date any covered family member receives a MILA Plan benefit to which the Member is not entitled if the benefit was received as a result of fraudulent or misleading conduct.
Your divorced spouse and dependent child	On the day you are divorced or on the date your marriage is annulled, if the dependent child is a stepchild.
Your dependent child or collateral dependent	On the last day of the month in which the individual no longer qualifies as a collateral dependent or a dependent child.
Your dependent child	On the date your child qualifies for coverage as a Member unless your child elects to waive coverage as a Member in order to remain under your family coverage.
Your dependent child	On the last day of the month in which your dependent child reaches age 26.

* See page 71 for a discussion of the hours' requirement for persons who work under a collective bargaining agreement with a different contribution rate.

If your eligibility for the MILA National Health Plan coverage ends, you may be eligible for continued coverage under COBRA. Also, see the Pensioner Benefits section beginning on page 80 for information concerning benefits for which you may qualify when you retire.

If You Are Eligible For Medicare Benefits

If you are covered under the Plan because of active employment and you or your covered dependents are entitled to Medicare coverage based on age or disability, you and your Medicare-eligible dependent do not have to enroll in Medicare to receive full Plan benefits.

However, if you or your Medicare-eligible dependent does enroll in Medicare, the Plan will provide the primary coverage and Medicare will be secondary for those who have enrolled in Medicare: (a) for as long as MILA coverage is a result of active employment, if your or your dependent's Medicare entitlement results from either disability or attainment of age 65; or (b) for 30 months if your or your dependent's Medicare entitlement results from end-stage renal (kidney) disease (ESRD) that began during your active employment.

Medicare coverage is not automatic for those who are eligible to enroll for it. You must enroll through the Social Security Administration (SSA) in order to be covered for Medicare Parts A and B. Medicare Part A does not require a premium payment if you are "fully insured" as defined by the SSA, but Medicare Part B coverage does require a premium payment. The Medicare Part B premium is set by the government and is expected to increase annually based upon the Consumer Price Index.

Medicare has two other Parts—Part C and Part D. You should not enroll for either coverage while you are covered under MILA by virtue of active employment. A Medicare Part C Plan is now called a Medicare Advantage Plan. Medicare Advantage Plans are provided through private insurance carriers and have been designed to replace coverage under Medicare Parts A and B for retired persons.

Medicare Part D is also provided through private insurance carriers or other companies and supplies prescription drug coverage in return for a premium payment. Because MILA coverage includes prescription drug coverage which is at least as complete and comprehensive as Medicare Part D coverage, you probably would not receive an additional benefit by enrolling in this coverage and paying the additional Medicare Part D premium.

Medicare rules for payment can be complex. If you have any questions about how these Medicare rules affect you, contact Medicare or MILA.

Medicare For Pensioners

If you are receiving a pension from a local port plan and you and your dependents are covered by MILA, and you are not covered by another medical plan by virtue of your or your spouse's active employment, and you are eligible to enroll in Medicare, you must enroll in both Medicare Part A and Medicare Part B in order to have complete coverage under MILA. On the date you retire, Medicare will become the primary payer of your benefits if you are entitled to Medicare benefits on that date. If you become entitled to Medicare after you retire, Medicare will become the primary payer of your benefits on the date you timely enroll and are first eligible for Medicare benefits. The Plan will supplement your Medicare benefits in order to supply you with complete coverage. If you do not timely enroll under the Medicare rules, the Plan will estimate the benefit that Medicare would have provided in both the discounted charge and the Medicare benefit payments, and the Plan will pay benefits as though Medicare had actually paid.

Therefore, it is extremely important for you to timely enroll in Medicare for both Parts A and B as soon as you are eligible to do so after you retire. See the Pensioner Benefits section beginning on page 80 of this SPD for more details.

MEDICARE

If You Are Eligible for Medicare: Generally, if you are a pensioner and are not covered under the Plan by virtue of active employment, Medicare provides your primary coverage, and the Plan provides secondary coverage. However, if your coverage results from active employment in the industry, the Plan is your primary coverage.

MILA coverage includes prescription drug coverage. If you are covered by the Plan as a pensioner and enroll in Medicare Part D, your MILA prescription drug coverage and the prescription drug coverage of any of your dependents will cease as of the date of entitlement for Medicare Part D benefits. If only your spouse enrolls in Medicare Part D prescription drug coverage, then only your spouse will lose MILA prescription drug coverage.

As discussed, Medicare Advantage Plans replace traditional coverage under Medicare Parts A and B and either include Medicare Part D prescription drug coverage or offer it in conjunction with the Medicare Advantage Plan. Typically, these plans offer regional coverage which is generally quite comprehensive for those willing to accept a reduction in the choice of medical providers.

If you elect such coverage instead of traditional Medicare Parts A and B, that coverage will replace your MILA coverage beginning with the date you are first entitled to Medicare Advantage Plan benefits. If your Medicare Advantage Plan includes Medicare Part D coverage or you have separately enrolled for that coverage, MILA will reimburse you for the cost of your regular Medicare Part B premium (the standard premium) when you supply proof of payment.

Note that there are certain exceptions to the order of payment as provided under the Medicare as Secondary Payer provisions of the Social Security Act and the Internal Revenue Code for persons receiving Plan benefits as a result of active employment.

For example, if you become entitled to Medicare because of ESRD while employed, Medicare will be the secondary payer for the first 30 months under current law. After that, Medicare will be the primary payer. This is true regardless of whether you are receiving Medicare benefits as a result of active employment or as a pensioner. If you have questions about how MILA will coordinate with Medicare benefits, you should contact Medicare or MILA.

If You Become Disabled

If you become disabled and qualify for workers' compensation benefits or accident-and-sickness benefits under a local port plan, you will receive credited hours during the period of your disability for purposes of determining your eligibility for future coverage under MILA. Hours will be credited in the contract year in which you are disabled based upon a rate determined by the benefit plan for which you qualified in the prior contract year.

Disability credited hours will be granted at the following rates per week, pro-rated for a partial week, assuming a five-day work week:

Benefit Plan	Disability Credited Hours	Maximum Number Of Credited Hours Each Contract Year
Premier Plan	26 Hours/Week	1,300
Basic Plan	20 Hours/Week	1,000
Core Plan	14 Hours/Week	700

Example 1: If you were disabled beginning August 29, 2019, when you were covered in the Basic Plan and your disability continued past September 30, 2019, you would receive 92 disability credited hours for the contract year ending September 30, 2019 (4.6 weeks times 20 hours per week). If you had earned at least 1,208 credited hours because of work during that contract year, you would have qualified for the Premier Plan in the 2020 calendar year and you would receive disability credited hours at the rate of 26 hours per week beginning in the first week in October 2019.

Example 2: If you become disabled and qualify for workers' compensation benefits or accident and sickness benefits under a local port plan before you are covered for MILA benefits, you will not receive disability credited hours for the remainder of that contract year.

Example 3: If you were not covered by MILA in 2019 but you earned 1,208 credited hours before you were disabled on August 29, 2019, you would not receive disability credited hours for the contract year ending September 30, 2019. If you continued to be disabled on October 1, 2019, you would earn credited hours at the rate of 20 hours per week, the rate for the Basic plan, which is the benefit plan under which you will be eligible to receive benefits beginning on January 1, 2020.

Disability Credited Hours Rules

MILA disability credited hours based upon the receipt of workers' compensation benefits or accident and sickness benefits provided by a local port plan are limited to 24 months per illness or injury (this is not a lifetime limit).

If you have received disability credited hours for 24 months, you may apply for up to an additional year of credited service by submitting an application to MILA to be examined by an independent medical examiner appointed by MILA. The decision by MILA on any application that you submit is final and binding, with no right of appeal. If that independent medical examiner determines that you remain temporarily disabled for purpose of longshore work, you will receive an additional year of credited service. You may apply for more than one additional

year of credited service by submitting subsequent applications to MILA annually. If after receiving one or more additional years of credited service, you return to work in the industry within 30 days of the termination of your workers' compensation benefits, you will (1) continue to receive your current MILA benefits for the remainder of the calendar year of that one-year extension and (2) earn during the contract year in which you returned to work in the industry eligibility for the calendar year following your return to work in the industry based upon a combination of your disability credited hours earned before you returned to work in the industry and your actual work hours earned after you returned to work in the industry.

If you submit an application, you will be examined by an independent medical examiner appointed by MILA, who will determine whether you are permanently disabled for purposes of performing longshore work. If the independent medical examiner determines that you are not permanently disabled for purposes of performing longshore work, your MILA benefits will terminate. You will then be entitled to elect COBRA Continuation Coverage.

If the independent medical examiner determines that you are permanently disabled for purposes of performing longshore work, you must (a) apply for a disability pension from your local port pension plan within six months of the independent medical examiner's determination, (b) apply to the Social Security Administration for disability benefits within 30 days of the date of MILA's letter concerning the independent medical examiner's determination, and (c) submit to MILA proof of your application to Social Security.

If you do not qualify for a disability pension from your local port pension plan, you can continue your current MILA benefits for a period of one year after the independent medical examiner's determination only if (a) you apply to the Social Security Administration for disability benefits within 30 days of the date of MILA's letter and (b) you submit proof of that application to MILA.

If you qualify for a disability pension from your local port pension plan and the Social Security Administration determines that you are disabled, your MILA benefits will continue until you become eligible for Medicare Parts A and B, at which time you will receive MILA Medicare Wrap-Around benefits. If you qualify for a disability pension from your local port pension plan but the Social Security Administration determines that you are not disabled, your MILA benefits will continue until you become eligible for Medicare Parts A and B, at which time you will receive MILA Medicare Wrap-Around benefits. Your dependents will be eligible for benefits under the MILA Plan provisions.

If you do not qualify for a disability pension from your local port pension plan but the Social Security Administration determines that you are disabled, your MILA benefits will continue until you become eligible for Medicare Parts A and B.

If you do not qualify for a disability pension from your local port pension plan and the Social Security Administration determines that you are not disabled, your MILA benefits will end on the later of (1) one year after the date of the independent medical examiner's determination, (2) December 31 of the following calendar year, if you have sufficient credits hours of service in the current calendar year, or (3) 60 days from the date on which the Social Security Administration issues its final determination or its decision on any appeal of that determination.

If you have enough credited hours of service to receive MILA benefits in the current calendar year. The one year of additional MILA benefits will start after the benefits based on your credited hours of service ends.

If your application to the Social Security Administration is still pending at the end of the one-year period, your MILA benefits will continue, provided that you submit proof to MILA that that application is still pending. Your MILA benefits will continue until the Social Security Administration has made a final determination on your application for Social Security disability benefits. If you appeal a determination by the Social Security Administration, your MILA benefits will continue while the appeal is pending, provided that you submit proof of that appeal to MILA.

You will continue to receive disability credited hours even after payments from workers' compensation or a local accident-and-sickness program end, provided you:

- Are still disabled as defined in the workers' compensation or local accident-and-sickness program;
- Submit proof of disability which is satisfactory to MILA;
- Have not retired; and
- Have not yet reached the 24-month maximum.

If you are receiving Social Security Disability Income (SSDI) benefits, you can no longer receive disability credited hours based upon the receipt of workers' compensation or accident-and-sickness benefits.

ID Cards: Proof Of Coverage

- You will receive ID cards showing the benefits (medical, pharmacy, dental, vision, or behavioral health) that you are eligible to receive as a Member of the Plan.
- The Cigna ID card demonstrates coverage for medical and behavioral-health benefits through Cigna as the Claims Administrator;
- The CVS Caremark ID card demonstrates coverage for prescription-drug benefits through CVS Caremark as the Claims Administrator; and
- The EyeMed ID Card demonstrates coverage for vision benefits through First American Administrators (FAA), a wholly owned subsidiary of EyeMed Vision Care, as the Claims Administrator.
- Effective April 1, 2014, Aetna ceased issuing ID cards for the dental coverage. Your dentist will confirm coverage directly with Aetna.

When Coverage Ends

The chart on page 79 shows when you and your dependents would lose your eligibility for coverage—assuming you do not elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and you are not eligible for pensioner benefits.

The Family Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) provides that if you work for an employer covered by that Act (generally employers with 50 or more employees), you are entitled to unpaid leave for specified family or medical purposes. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your employer.

Termination Of MILA Coverage Because Of Active Duty Military Service

If you enter active duty military service for a period of 31 days or more with the United States armed forces, your coverage under the Plan will end on the date you enter such service. However, if you enter service with the United States Armed Forces (e.g., the Army, Navy, Marine Corps, Air Force or Coast Guard) and you have re-employment rights as provided in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended, Plan coverage will continue for your dependent spouse and children while your reemployment rights continue under that law. If your re-employment rights end under that law (for example, because you re-enlist or extend your enlistment), coverage will end for your dependents on that date.

When your active duty military service ends, if your re-employment rights are guaranteed under USERRA and if you return to employment in the industry under covered Master Contract employment within the time required under USERRA, your coverage in the Plan will be reinstated on the date of your return under the benefit plan in which you were covered when you entered active duty military service. If the benefit plans were amended while you were in active duty military service, you would be reinstated in the amended plan. Be certain to notify your local port administrator or MILA when you return to work in order that your coverage may be promptly restored.

You will continue to be covered in this plan until the end of the calendar year following the end of the contract year in which you returned. For purposes of qualifying for coverage in the next calendar year, the MILA Trustees will grant USERRA Credited Hours for each week of the contract year prior to the date of your return. Hours will be credited for the weeks prior to your return at the weekly rate at which you actually earned credited hours in that contract year following your return.

Continuation Coverage Under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, group health plans are required to offer temporary continuation of health coverage in certain situations when coverage would otherwise end. You may continue coverage for yourself and for

each person who qualifies as an eligible dependent under the Plan provided that you elect continued coverage in a timely manner and pay the cost required.

However, only a person covered under the Plan before the initial Qualifying Event which caused your loss of coverage or a child born to or adopted by you following the initial Qualifying Event will be considered a Qualified Beneficiary. In general, a Qualified Beneficiary is you, your spouse or your dependent children who were covered under the Plan on the day before the initial Qualifying Event. Collateral dependents are not Qualified Beneficiaries. Qualified Beneficiaries have a separate right to elect coverage if you do not elect to cover them or if they subsequently lose coverage under the Plan due to a subsequent Qualifying Event. The chart on page 79 shows which Qualified Beneficiaries may elect continued coverage under COBRA, when loss of coverage due to a Qualifying Event occurs, and how long the Qualified Beneficiary may continue coverage.

In general, on the date you enroll in and become entitled to benefits under Medicare, your coverage under COBRA continuation ends. However, if you were covered under Medicare before continuation coverage was elected, you may elect to be covered under COBRA continuation coverage. Please keep in mind that the following information is a summary of the law and, therefore, is general in nature. When the Plan receives notice that your coverage has terminated due to a Qualifying Event, it will provide you with a complete notice of your rights and obligations if you elect continued coverage.

If you marry, have a newborn child, or have a child placed with you for adoption while you are covered under COBRA, you may enroll that spouse or dependent child for coverage for the balance of the COBRA continuation period under the same conditions that apply to active members. Only children born to or adopted by you will be Qualified Beneficiaries. Your new spouse and any of your spouse's children on that date will not be Qualified Beneficiaries. The same rules which govern dependent eligibility and qualifying changes in family status that apply to active members will apply to persons covered under COBRA continuation coverage.

Other Options

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.

Enrolling In Medicare Instead Of COBRA Continuation Coverage After MILA Coverage Ends

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and instead elect COBRA continuation coverage, you may have to pay a Medicare Part B late enrollment penalty and you may have a gap in coverage if you decide later you want Medicare Part B. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit <https://www.medicare.gov/medicare-and-you>.

Notice Of A Qualifying Event

Under the law, you or your dependent are responsible for providing notice to the Plan of the occurrence of certain Qualifying Events under which you or your dependent will lose coverage under the Plan. Those Qualifying Events are the loss of coverage due to (1) your divorce and (2) your child ceasing

to be an eligible dependent under the Plan. If you lose coverage due to your reduction in hours, termination of employment, or death, the Plan must be notified within 60 days of the later of: (1) the date of the event or (2) the date coverage would end under the Plan because of the Qualifying Event. Your employer is responsible for notifying the Plan of the occurrence of one of these Qualifying Events:

- Your death;
- The termination of your employment; or
- The reduction in your hours of employment.

The time period in which your employer must notify the Plan of one of these Qualifying Events commences on the date of the loss of coverage. Once the Plan is notified of any of these events, the Plan will send you a COBRA notice as soon as possible, but in no event later than 44 days after the Plan receives notice of the Qualifying Event.

Making A COBRA Election

Once the Plan receives notice of your Qualifying Event, it will send you a notice of your right to elect COBRA Continuation Coverage. You will have up to 60 days from the date of the notice to elect coverage and an additional 45 days from the date you elect continuation coverage to pay the initial COBRA premium. The initial premium due is equal to the total of all premiums due from the date coverage was lost until the end of the month in which the premium is paid. The election form will provide the current cost for COBRA Continuation Coverage.

COBRA Continuation Coverage will not begin unless timely election to continue coverage is made and all initial premiums due are paid. COBRA Continuation Coverage will begin retroactive to the date coverage was lost. Each Qualified Beneficiary has a separate and independent right to elect COBRA Continuation Coverage. This means that each Qualified Beneficiary can decide for himself or herself whether to continue coverage.

If your rights to continuation coverage end (for example, because you did not timely elect or you did not pay the required premium), the Plan will notify you of the date that this has occurred. If your COBRA rights end for any reason, they may not be reinstated.

Paying For COBRA Coverage

If you or your dependents who are Qualified Beneficiaries elect to continue coverage, you or they must pay the full cost of the coverage elected. The Plan is permitted to charge the full cost of coverage for you and your dependents plus an additional 2%.

The initial payment is due no later than 45 days after the election to receive coverage (and it will cover the period from the date on which you lost coverage until the end of the month next following or coinciding with the date your payment is received).

Coverage will not be continued unless timely election of COBRA Continuation Coverage occurs, and the full initial payment is made within the time required. Thereafter, payments are due monthly on the first of each month and are considered to be on time if they are made within 31 days of the due date. Costs for COBRA Continuation Coverage are expected to change annually on January 1st.

Contact the Plan for more information about the cost of your COBRA Continuation Coverage. If you fail within the time limit provided to notify the Plan of your decision to elect COBRA Continuation Coverage and to make the required initial payment, your coverage will not continue beyond its original termination date under the terms of the Plan. Further, if you do not pay the required monthly COBRA payment within the permitted time limit, COBRA Continuation Coverage will end as of the end of the month for which the last complete payment was made, and your coverage will not be reinstated.

If your rights to COBRA Continuation Coverage end (for example, because you did not timely elect or you did not timely pay the required premium), the Plan will notify you of the date that this has occurred. If your COBRA rights end for any reason, they will not be reinstated.

What COBRA Coverage Provides

COBRA Continuation Coverage is identical to your coverage in the Plan before it terminated. COBRA Continuation Coverage provides for uninterrupted coverage during the period of such continuation.

However, the MILA Trustees have decided to offer, as an alternative to continuation of your current coverage, continuation under an alternative lower costing benefit plan. This alternative is available only to members who are working under the Master Contract and their covered dependents. For example, if you were covered as an active participant under the Premier plan

when coverage terminated, the standard continuation coverage would be in the Premier plan without any interruption. However, any Qualified Beneficiary could decide, instead, to elect coverage under the Basic or Core plan because those plans have a lower premium. If you were to choose such lower cost coverage, the new coverage would begin on the date you lost your Premier plan coverage, it would have a new deductible and a new out-of-pocket maximum based upon your new benefit that would begin to accumulate on the day following the termination of your Premier benefit coverage. In other respects, it would be COBRA Continuation Coverage in the lower benefit and lower cost coverage subject to all COBRA rules for continuation coverage. Also, once you elect the alternative coverage, you cannot change your mind and switch back to the Premier plan benefit.

If, during the period of COBRA Continuation Coverage, the Plan's benefits change for active Members, the same changes will apply to COBRA participants. If, during a period of COBRA Continuation Coverage, a Qualified Beneficiary ceases to be an eligible dependent under the Plan, that Qualified Beneficiary may separately elect COBRA Continuation Coverage for himself/herself.

However, the total of all periods of COBRA Continuation Coverage for any person, measured from the initial Qualifying Event, will be no longer than 36 months.

When COBRA Coverage Ends

COBRA coverage ordinarily ends at the end of the maximum coverage period specified in the chart below. It will stop before the end of the maximum period under any of the following circumstances:

- The required monthly COBRA payment is not made on time or within the 31-day grace period for such payment;
- A person covered under COBRA Continuation Coverage becomes entitled to benefits under Medicare after the date of the COBRA election, or becomes covered under another group health plan; or
- A person covered under COBRA Continuation Coverage fails to qualify as an eligible spouse or dependent child. If the eligible spouse or dependent child is a Qualified Beneficiary, they will have a separate right to elect COBRA Continuation Coverage for the balance of the maximum period.

COBRA Continuation Coverage After a Qualifying Event

Coverage May Continue For	If Coverage Terminates Because Of This Qualifying Event	Maximum Duration Of Coverage
You, your spouse and children	Your covered employment terminates for reasons other than gross misconduct and you have no right to any continued MILA benefits based upon your employment hours.	36 months
You, your spouse and children	You become ineligible for coverage due to a reduction in your employment hours.	36 months
You*	You go on active duty in the U.S. military for 31 days or more.	36 months
Your spouse and children	You die.	36 months
Your spouse	Your divorce or your marriage is annulled.	36 months
Your child	Your dependent child reaches age 26.	36 months
Your spouse and children	After becoming covered for COBRA continuation coverage, you become covered for Medicare benefits.	36 months

*If you are called to active duty in the U.S. military, your dependents will continue to be covered under the Plan as described on page 76.

Coverage also ends if the Plan stops providing health plan benefits to all its participants. Once your COBRA Continuation Coverage terminates for any reason, it cannot be reinstated.

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.

Can I enroll in Medicare instead of COBRA Continuation Coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA Continuation Coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA Continuation Coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA Continuation Coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA Continuation Coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If You Have Questions

Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit <http://www.dol.gov/ebsa>. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Health Insurance Marketplace, visit www.HealthCare.gov.

Pensioner Benefits

Members Who Retire On A Disability Pension

If you apply to receive MILA benefits on or after October 1, 2014, you will qualify for MILA benefits if (1) you present proof to MILA that you have applied to the Social Security Administration for Social Security Disability Income (SSDI) Benefits or, if qualified, for regular unreduced Social Security Income Benefits and (2) you have been determined to be permanently disabled for purposes of performing longshore work by an independent medical examiner appointed by MILA. If that independent medical examiner determines that you are not permanently disabled for purposes of performing longshore work, you may seek a determination from MILA's Board of Trustees. If the Board of Trustees determines that you are not permanently disabled for purposes of performing longshore work, you will no longer be eligible for MILA benefits.

Members Who Leave The Industry Without Retiring

If you leave the industry without retiring and are eligible for a vested pension benefit when you leave the industry, you will not be eligible to receive any Plan benefits when you retire. You leave employment in the industry if both of the following conditions apply: (1) you are no longer working pursuant to the

terms of the USMX-ILA Master Contract and (2) you did not immediately start receiving a pension at the conclusion of such work pursuant to the terms of a local Port longshore pension plan after leaving employment in the industry.

NOTE

Any former Member, who:

- Before September 30, 2004, was no longer in the industry but had sufficient service to qualify for a vested pension benefit under the local Port longshore pension plan's normal retirement age; and
- Was entitled to receive health care benefits in retirement pursuant to the local Port rules which were in effect on September 30, 1996;

shall be eligible to receive MILA Medicare Wrap-Around Plan benefits when the Member attains age 65.

Members Who Retire At Any Age And Are Not Eligible To Receive MILA Benefits In Retirement

If you retire under your local Port longshore pension plan and you are not qualified to receive Plan benefits in retirement under the terms of the USMX-ILA Master Contract, you will receive continued active level benefits for which you qualified on the date you retired but only for the period for which you would have been covered if you had ceased work and did not retire.

Members Who Retire At Age 57 Or Younger With 25 Or More Years Of Pension Service

If you retire under your local Port longshore pension plan with 25 or more years of pension service prior to attaining age 58 and you are eligible to receive MILA retirement benefits pursuant to the USMX-ILA Master Contract, you will receive the following benefits:

- Prior to attaining age 58, you will receive the benefit plan you were receiving on the day prior to your retirement until the earlier of:
 - the end of the period for which you qualified for that benefit plan; or
 - the attainment of age 58 or Medicare eligibility as described in the section below.
- On attainment of age 58, you will receive Basic plan benefits. However, if you qualified for Premier plan benefits on the date you retired and if those benefits continue until you attain age 58, then you will continue to receive such benefits until the end of the period for which you qualified for such benefits; thereafter, you will receive Basic plan benefits. When you attain age 62, your benefit plan will change to the Premier plan. When you attain Medicare eligibility, your benefits will change to MILA Medicare Wrap-Around benefits, provided that you enroll in Medicare Parts A and B.
- If you have a spouse who is qualified for welfare benefits in retirement pursuant to the USMX-ILA Master Contract, your spouse will receive the benefit plan for which you are eligible by virtue of your age or pension service until your spouse attains Medicare eligibility; thereafter, your spouse will receive MILA Medicare Wrap-Around benefits, provided that your spouse enrolls in Medicare Parts A and B. Dependents other than your spouse will be eligible for benefits pursuant to the regular eligibility rules for those dependents.

Members Who Retire After Attaining The Age Of 58 And Before Age 62 With 25 Or More Years Of Pension Service

If you retire under your local Port longshore pension plan with 25 or more years of pension service after having attained age 58 and you are qualified to receive MILA retirement benefits pursuant to the USMX-ILA Master Contract, you will be a qualified pensioner under MILA and will receive the following benefits:

- You will receive Basic plan benefits. However, if you qualified for Premier plan benefits on the date you retired, you will continue to receive such benefits until the end of the period for which you qualified for such benefits; thereafter, you will receive Basic plan benefits. When you attain age 62, your benefit plan will change to the Premier

plan. When you attain Medicare eligibility, your benefits will change to MILA Medicare Wrap-Around benefits, provided that you enroll in Medicare Parts A and B.

- If you have a spouse who is qualified for welfare benefits in retirement pursuant to the USMX-ILA Master Contract, your spouse will receive the benefit plan for which you are eligible by virtue of your age or pension service until your spouse attains Medicare eligibility; thereafter, your spouse will receive MILA Medicare Wrap-Around benefits, provided that your spouse enrolls in Medicare Parts A and B. Dependents other than your spouse will be eligible for benefits pursuant to the regular eligibility rules for those dependents.

Members Who Retire After Attaining The Age Of 62 With 25 Or More Years Of Pension Service

If you retire under your local Port longshore pension plan with 25 or more years of pension service after attaining age 62 and you are eligible to receive Plan retirement benefits pursuant to the USMX-ILA Master Contract, you will be a qualified pensioner under the Plan and will receive the following benefits:

- You will receive Premier plan benefits until you attain Medicare eligibility. Then, you will receive MILA Medicare Wrap-Around benefits, provided that you enroll in Medicare Parts A and B.
- If you have a spouse who is qualified for welfare benefits in retirement pursuant to the USMX-ILA Master Contract, your spouse will receive Premier plan benefits until your spouse attains Medicare eligibility; thereafter, your spouse will receive MILA Medicare Wrap-Around benefits, provided that your spouse enrolls in Medicare Parts A and B. Dependents other than your spouse will be eligible for benefits pursuant to the regular eligibility rules for other dependents.

Members Who Retire At The Age Of 65 Or Older With 25 Or More Years Of Pension Service

If you retire under your local longshore Port pension plan with 25 or more years of pension service after attaining age 65 and

you are eligible to receive Plan retirement benefits pursuant to the USMX-ILA Master Contract, you will be a qualified pensioner under the Plan and will receive MILA Medicare Wrap-Around benefits, provided that you enroll in Medicare Parts A and B.

If you have a spouse who is qualified for welfare benefits in retirement pursuant to the USMX-ILA Master Contract, your spouse will receive Premier plan benefits until your spouse attains Medicare eligibility; thereafter, your spouse will receive MILA Medicare Wrap-Around benefits, provided that your spouse enrolls in Medicare Parts A and B. Your dependents other than your spouse will be eligible for benefits pursuant to the regular eligibility rules for other dependents.

Members Who Retire With Less Than 25 Years Of Pension Service

If you retire under a local Port longshore pension plan with fewer than 25 years of pension service, regardless of your age, and you are eligible to receive MILA retirement benefits pursuant to both the USMX-ILA Master Contract and your local Port welfare plan rules in effect on September 30, 1996, you will be a qualified pensioner under the Plan and will receive the following benefits:

- Prior to attaining age 65 you will receive the benefit plan for which you qualified on the day prior to your retirement until the earlier of:
 - the end of the period for which you qualified for such benefit plan; or
 - your attainment of age 65, when you will receive MILA Medicare Wrap-Around benefits, provided that you enroll in Medicare Parts A and B.

The application of this rule may result in the suspension of Plan benefits in the period prior to your attainment of age 65.

- If you retire after attaining age 65 and without having 25 or more years of service and you are qualified to receive MILA retirement benefits pursuant to both the USMX-ILA Master Contract and the local Port welfare plan rules in effect on September 30, 1996, you will receive MILA Medicare Wrap-Around benefits, provided that you enroll in Medicare Parts A and B.
- If your spouse is qualified for welfare benefits in retirement pursuant to both the USMX-ILA Master Contract and the local Port welfare plan rules in effect on Sep-

tember 30, 1996, then your spouse will receive MILA Medicare Wrap-Around benefits for as long as provided in that local Port welfare plan, provided that your spouse has enrolled in Medicare Parts A and B.

If you do not meet your local Port Welfare plan rules in effect on September 30, 1996, you will not be eligible for any MILA benefits including the MILA Wrap-Around plan.

Pensioners Who Return To Active Service In The Industry

In those ports which permit a pensioner who is receiving a pension from a local Port longshore pension plan to return to active service, if you are receiving MILA pensioner benefits and return to active service, you will be eligible for MILA benefits as follows:

- If you have not attained 58 years of age or have fewer than 25 years of service as determined by your local Port pension rules, you will not be entitled to Plan benefits until you qualify for MILA benefits based on your hours worked after you return to active service, unless you are still eligible for MILA benefits based on your hours of work.
- If you are 58 years of age or older and have at least 25 years of service as determined by the local Port pension rules, you will receive Basic plan benefits between the date of your return to active service and the end of the calendar year following the end of the contract year in which your return to active service occurs. Thereafter, your benefits will be based upon credited hours as constructed using the formula on on this page.
- If you return to active service before having exhausted eligibility for the MILA Premier plan benefits for which you would have been entitled had you not retired, you will be entitled to receive Premier plan benefits from the date of your return to active service until the end of the last calendar year for which such benefits had been earned. If you had been receiving Premier plan benefits as your retirement benefit, then you will continue to receive those benefits until the end of the calendar year following the end of the contract year of your return. Thereafter, your benefits will be based upon credited hours as constructed using the formula on this page.
- If you return to active service after retiring on a disability pension from your local Port pension plan, you

will receive Basic plan benefits between the date of your return to active service and the end of the calendar year following the end of the contract year in which your return to active service occurs. Thereafter, your benefits will be based upon credited hours as constructed using the formula on this page.

- If you retire from active service and you and your spouse are covered under the MILA Medicare Wrap-Around plan, and you subsequently return to active service and become covered in MILA based upon active service, when you subsequently retire and again become covered in the MILA Medicare Wrap-Around plan, the benefits of that plan will be reduced by any benefits used during the prior period or periods of retirement coverage in the MILA Medicare Wrap-Around plan.
- Constructed hours during the contract year of return will consist of two segments: (1) the hours you actually worked in the contract year in which you return to active service plus (2) constructed hours for the period beginning with the first day of that contract year and ending on the work day immediately preceding the date you returned to work. Constructed hours will be granted at the following rate depending upon the benefit plan in which you participated on the date immediately preceding the day you retired: for the Premier plan, 26 hours per week; for the Basic plan, 20 hours per week; and for the Core plan, 14 hours per week.
- If you retire under your local Port longshore pension after April 30, 2008, you will receive constructed hours upon return to active longshore work as described above only one time. In a subsequent return to active work under the conditions described in this section, any MILA benefits to which you were entitled as a pensioner will cease upon such return to active work and the future entitlement to MILA benefits will be based upon the hours actually worked after you returned to active service unless the MILA Trustees determine that you had to return to active service due to a hardship. If the MILA Trustees determine that the return to active work was occasioned by hardship, then MILA coverage will be granted under the terms described in this section.

Employer Port Association Retirees

- To qualify for MILA Pensioner benefits, a Port Association Retiree must be receiving a defined-benefit pension based upon the Port Association Retiree's employment in the industry. If the Port Association Retiree is not receiving a defined-benefit pension, the Port Association

Retiree must be entitled to participate in a company sponsored retirement plan.

- If the Port Association Retiree is at least 58 years old when the Port Association Retiree retires, the Port Association Retiree will qualify for MILA Basic plan benefits, provided that the Port Association Retiree has at least 25 years of service in the longshore industry and the Port Association Retiree has worked at least five years with the association immediately before the Port Association Retiree's retirement. At age 62, the Port Association Retiree will receive MILA Premier plan benefits and at age 65, or upon becoming eligible to enroll in Medicare, if earlier, the Port Association Retiree will receive MILA Medicare Wrap-Around benefits, provided that the Port Association Retiree has enrolled in Medicare Parts A and B.
- If the Port Association Retiree is at least 62 years old when the Port Association Retiree retires, the Port Association Retiree will qualify for MILA Premier plan benefits, provided that the Port Association Retiree has at least 25 years of service in the longshore industry and the Port Association Retiree has worked at least five years with the association immediately before the Port Association Retiree's retirement. At age 65, or upon becoming eligible to enroll in Medicare, if earlier, the Port Association Retiree will receive MILA Medicare Wrap-Around benefits, provided that the Port Association Retiree has enrolled in Medicare Parts A and B.
- If the Port Association Retiree is at least 65 years old when the Port Association Retiree retires, the Port Association Retiree will qualify for MILA Medicare Wrap-Around benefits, provided that the Port Association Retiree has at least ten years of service in the longshore industry and the Port Association Retiree has worked at least five years with the association immediately before the Port Association Retiree's retirement, and provided that the Port Association Retiree has enrolled in Medicare Parts A and B.
- Any Port Association Retiree receiving MILA Pensioner benefits shall no longer be eligible to receive MILA benefits if the Port Association Retiree goes to work for an employer that is in the longshore industry. Other than such a Port Association Retiree, once a Port Association Retiree has met the initial requirements to receive MILA Pensioner benefits, a Port Association Retiree's benefits will not be discontinued, provided that MILA is still providing MILA Pensioner benefits.

- The term "in the longshore industry," as used within this section, includes employment in (1) any company that was a signatory to a deepsea collective bargaining agreement covering ports in the United States, except Alaska and Hawaii; or (2) any company bound by the terms of any deepsea collective bargaining agreement covering ports in the United States, except Alaska and Hawaii, with a multi-employer bargaining association by reason of being a member of such association.

If You Are Eligible For Medicare When You Retire

About Medicare

If you are retired, once you become eligible to enroll in Medicare, it will immediately become your primary coverage. You can enroll in either:

- Traditional Medicare (see below); or
- A Medicare Advantage Plan (see pages 74 and 85).

How Traditional Medicare Works

Medicare is basic health insurance provided by the government for people who qualify due to age (currently age 65), a disability, or end-stage renal (kidney) disease (ESRD). It is offered in four parts:

- Part A is hospital insurance. For people who have worked in Social Security covered employment and paid Social Security and Medicare taxes for a number of years, no premium is required for this coverage. It covers most of the cost of a hospital stay and other institutional care after the Part A deductible, which applies to each "spell of illness" as defined by Medicare, is paid.
- Part B is medical insurance. After you pay the annual Part B deductible, Medicare will pay 80% of the cost for the covered services of Medicare participating doctors; it will pay 100% if the doctor accepts assignment from Medicare. You will pay for Part B through monthly premium payments deducted from your Social Security check if you are drawing Social Security payments; otherwise, the Social Security Administration will bill you quarterly.

- Part C is additional insurance coverage. Medicare Part C is another name for Medicare Advantage, which is administered by private insurance companies contracted with Medicare. Medicare Part C covers everything that Original Medicare (Part A and Part B) cover and may cover extra benefits as well.
- Part D is prescription coverage. Because MILA provides prescription benefits which are at least as good if not better than the prescription benefits provided through the Part D programs, you should not join a Medicare Part D program unless you elect coverage in a Medicare Advantage Plan.

You Must Enroll In Medicare Parts A And B To Receive Complete MILA Pensioner Benefits

On the date you retire, if you are eligible to enroll in Medicare and you qualify for coverage under the MILA National Health Plan as a pensioner (or the dependent of a pensioner), you must enroll in Medicare Parts A and B, in order to have complete coverage.

If you become eligible to enroll in Medicare after you retire, you must enroll within Medicare's initial eligibility period. If you are eligible for Medicare and do not enroll, you will not receive full benefits. That is because the Plan will calculate the benefit you would have received from Medicare beginning with the date you first could have been entitled to Medicare benefits, and will reduce your Plan benefit accordingly. After you enroll in Medicare, you have the following options under the MILA Plan:

- You can receive traditional Medicare coverage and MILA Medicare Wrap-Around Plan benefits; or
- You can enroll in a Medicare Advantage Plan which includes Part D coverage or in a Medicare Advantage Plan and a separate Part D Plan. If you enroll in this type of plan that provides Part D coverage, the only benefit which MILA provides is reimbursement for the standard monthly Medicare Part B premium.

Medicare Advantage Plans — Part C

The federal government introduced the Medicare Advantage Plan program to offer more choices to Medicare recipients. It includes a wide variety of managed health care options, such as Medicare HMOs, that are provided by private insurance companies. The options available to you depend on where you live and may change over time. The benefits offered under these plans must be equal to or greater than those offered in traditional Medicare. However, the plans may restrict your choice of provider. The private companies that offer Medicare Advantage Plans have the right to modify or terminate these plans each year.

If you enroll in a Medicare Advantage Plan, you are still in Medicare and you maintain all the rights and protections of the Medicare program. If the company that provides your Medicare Advantage Plan terminates its program, you have the right to rejoin traditional Medicare or choose another Medicare Advantage Plan.

You also have the right to change from one Medicare Advantage Plan to another or to traditional Medicare annually during Medicare's "open enrollment period." If you rejoin traditional



Medicare, notify MILA and provide the necessary proof of the date of change.

If you remain eligible for pensioner health benefits, MILA will restore your MILA Medicare Wrap-Around Plan benefits as of that date.

If you elect a Medicare Advantage Plan that includes prescription drug coverage (either as part of the plan or as a separate Medicare Part D Prescription Drug Program), you will be eligible for reimbursement for the cost of the standard monthly premium for Medicare Part B. MILA will reimburse you quarterly following the end of the calendar quarter (March 31, June 30, September 30 and December 31) for the standard premium.

To be reimbursed, you must provide MILA with the proof that you were enrolled in a Medicare Advantage Plan for the quarter by supplying copies of the following materials:

- If you are covered in a Medicare Advantage Plan that includes prescription drug coverage and that plan charges a supplemental premium, provide MILA with copies of the Medicare Advantage Plan bills which you paid for the quarter;
- If you are covered in a Medicare Advantage Plan that does not include prescription drug coverage, provide MILA with copies of the Medicare Advantage Plan bills and the Medicare Part D Prescription Drug Plan bills which you paid for the quarter; and
- If your Medicare Advantage Plan does not charge an additional premium, then MILA will request that once per year you obtain a statement from the Medicare Advantage Plan that confirms your enrollment.

If you are enrolled in a separate Medicare Part D Prescription Drug Plan, you must still supply copies of those bills quarterly.

If you elect a Medicare Advantage Plan option without prescription medication coverage and you do not purchase Medicare Part D separately, MILA will not reimburse you for the standard monthly Medicare Part B premium. Also, MILA will not pay any supplemental premiums imposed by the Medicare Advantage Plan or any Medicare Prescription Drug Plan premium or any prescription drug costs. Similarly, if you must pay a premium which is greater than the standard Medicare Part B premium or if you must pay a premium to enroll in Medicare Part A, MILA will not reimburse you for the cost of this additional premium.

Claims and Appeals

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The law provides that each welfare plan that is subject to ERISA must set up reasonable rules for filing a claim for benefits. To that end, this Summary Plan Description includes a detailed explanation of the claims filing and appeals procedures. The general rules and procedures, as well as your rights under ERISA, that relate to filing claims for benefits under the MILA National Health Plan have been described. In addition, the procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision have been supplied.

Claims For Benefits

A claim for benefits is a request for Plan benefits made in accordance with the Plan’s claims procedures. In order to file a claim for benefits offered under this Plan, you must complete a claim form from the applicable Claims Administrator—Cigna, CVS Caremark, Aetna or First American Administrators (FAA), a wholly owned subsidiary of EyeMed Vision Care. However, if you receive In-Network benefits from a participating provider (as described in the applicable sections of this SPD), you will not have to submit a claim. All claims for benefits must have been filed prior to the end of the second calendar year following the date the claim was incurred in order to be eligible for payment under the Plan.

In general, under the Plan’s rules, simple inquiries about the Plan’s provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits.

Chart Of Time Limits In Appealing A Claim

The following time limits apply for the Claims Administrator to respond after you file a claim with the appropriate Claims Administrator.

Claims Administrators	Cigna Healthcare For Medical And Behavioral Health Claims, CVS Caremark For Prescription Drug Claims, Aetna For Dental Claims and FAA/EyeMed For Vision Claims		
	Urgency of Appeal	Urgent Care	Non-Urgent Care Pre-Service Claims
For initial benefit determination	72 hours	15 days	30 days
To extend initial benefit determination	None	15 days	15 days
To notify claimant of improperly filed or incomplete claim	24 hours	5 days	30 days
For claimant to supply missing information	48 hours minimum	45 days	45 days
For claimant to appeal initial adverse benefit determination	180 days	180 days	180 days
For Plan to make a determination on appeal	45 days	30 days (15 days if the Plan has two appeals)	60 days (30 days if the Plan has two appeals)
For Plan to extend determination of appeal	45 days	None	None

The table provides a summary of the time limits that apply for each type of appeal. Please read the description which follows carefully to properly understand your rights when you file a claim and when you wish to formally appeal the denial of a claim. Please note that if a claim has been denied and you wish to better understand the reasons for the denial, you may call the Claims Administrator to discuss the denial without changing your rights to appeal. Also, note that vision claims will all be governed by the “Non-Urgent Care Post-Service Claims” time limits because of the way in which the Plan operates.

A request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. In addition, when you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not a claim under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal the denial by using these procedures.

A claim form may be obtained from the administrator responsible for processing the claim (the Claims Administrator), from the MILA Fund Office or from your local Port Administrator. Claim forms are also available on MILA's website.

Payment Of Claims

Benefits under the Plan, except for all In-Network claims and out-of-network inpatient hospital claims, shall be payable to you, provided however, that the Claims Administrator, in its discretion, may pay such benefits (less any overpayments previously paid by the Plan), as follows:

- a. To a provider furnishing services, supplies, care or treatment for benefits; or
- b. To any person, including your dependent, who has paid a provider for such services, supplies, care or treatment, except inpatient hospital claims. Such payments shall constitute a full discharge of the liability of the Trustees and the Plan to the extent of the benefits so paid; or
- c. According to a valid assignment of benefits.

Non-Assignment Of Benefits

Except as provided above, you do not have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute or anticipate any benefit payment hereunder, and any such payment shall not be subject to any legal proceeding for levy, execution, attachment, or garnishment.

Authorized Representatives

You may designate an authorized representative, such as your spouse or your doctor, to complete the claim form for you if you are unable to complete the form. A form can be obtained

from the MILA Fund Office or the applicable Claims Administrator to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim without your having to complete the special authorization form.

Definition Of Types Of Claims

There are four types of claims which may be submitted under the Plan, and the timing within which the Claims Administrator must respond to each type is different. The types of claims are as follows.

Urgent Care Claim

An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an Urgent Care Claim is determined by the Claims Administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above will be treated as an Urgent Care Claim.

Non-Urgent Pre-Service Claim

A Non-Urgent Pre-Service Claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Under this Plan, services that require prior approval are described on page 27–28.

IMPORTANT

If you use Out-of-Network providers, the Plan will reduce your reimbursement if you fail to precertify certain types of treatment. Please see the discussion relating to these reductions for medical treatment on pages 28–29 and for mental health or substance abuse on page 37.

Concurrent Care Claim

A Concurrent Care Claim is a claim that is reconsidered after an initial approval for care was made and results in a reduction or termination of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation, a decision to reduce or terminate treatment is made concurrently with the provision of treatment.

Post-Service Claim

A Post-Service Claim is a claim that involves the reimbursement for the cost of care that already has been received.

Timing For Initial Benefit Determination

For all ERISA Plans, the law allows a reasonable amount of time for the Claims Administrator to evaluate a claim and decide whether to pay benefits based on the information contained in the claim. Under the ERISA Claims and Appeals rules, these timeframes are dictated by what type of claim is being considered and whether you followed the proper procedures, as described in this section. The claims procedures for medical, mental health and substance abuse, dental, vision and prescription drug benefits will vary depending on whether your claim is for an Urgent Care, Non-Urgent Pre-Service, Concurrent Care or Post-Service Claim. Read each section carefully to determine which procedure is applicable to your request for benefits.

Urgent Care Claim

If you are requesting precertification of an Urgent Care Claim, the time deadlines are different. The Claims Administrator will respond to you and/or your doctor with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim. The determination will subsequently be confirmed in writing. If you improperly file an Urgent Care Claim, you will be notified of the proper procedures as soon as possible but not later than 24 hours after receipt of the claim. Unless the claim is resubmitted properly, it will not constitute a claim.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Claims Administrator will notify you and/or your doctor as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor will have 48 hours to provide the specified information. If the information is not provided within that time, your claim will be denied.

NOTE

Claims involving Urgent Care (as defined) must be submitted by telephone to the applicable vendors (Cigna or CVS Caremark) at the number listed on the back of your ID card.

Non-Urgent Pre-Service Claim

For a properly filed Non-Urgent Pre-Service Claim, you and/or your doctor will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for a response may be extended up to 15 days if necessary due to matters beyond the control of the Claims Administrator responsible for making the determination. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you improperly file a Non-Urgent Pre-Service Claim, you will be notified as soon as possible, but not later than five days after receipt of the claim, of the proper procedures to be followed

in filing a claim. You will only receive notice of an improperly filed Non-Urgent Pre-Service Claim if the claim includes the following important information:

- your name;
- your specific medical condition or symptom; and
- a specific treatment, service or product for which approval is requested.

Unless the claim is resubmitted properly, it will not constitute a claim.

If an extension of time is needed because the Claims Administrator responsible for making the determination needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice either for 45 days or until the date you respond to the request (whichever is earlier).

The Claims Administrator then has 15 days to make a decision on the Non-Urgent Pre-Service Claim and notify you of the determination. You have the right to appeal a denial of your Non-Urgent Pre-Service Claim.

Concurrent Care Claim

If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination of treatment before the end of such period of time or number of treatments is an adverse benefit determination. The Claims Administrator must notify you at a time sufficiently in advance of the reduction or termination to allow you to appeal.

Post-Service Claim

Ordinarily, you will be notified of the decision on your Post-Service Claim within 30 days from receipt of the claim by the Claims Administrator responsible for paying the claim. This period may be extended one time by the applicable Claims Administrator for up to 15 days if the extension of time

is necessary due to matters beyond the control of the Claims Administrator. If an extension of time is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision. If an extension of time is needed because the Claims Administrator needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied.

During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice either for 45 days or until the date you respond to the request (whichever is earlier). The Claims Administrator responsible for paying the claim will then have 15 days to make a decision on a Post-Service Claim and notify you of the determination.

When/Where To File Claims

Claims for benefits should be filed as soon as reasonably possible in order that timely payment may be made. Claims must have been filed prior to the end of the second calendar year following the date the claim was incurred in order to be eligible for consideration for payment under the Plan. Failure to file claims within the time required shall not invalidate or reduce any claim if it can be demonstrated that it was not reasonably possible to file the claim within such time.

You are generally not required to file a claim for In-Network benefits. When you file a claim for Out-of-Network benefits, submit a completed claim form to the Claims Administrator responsible for the administration of the benefits you are requesting. Your claim will be considered to have been filed as soon as it is received by the appropriate Claims Administrator. Claims should be filed with the appropriate Claims Administrator at the address shown in the sections that follow.

When you need to submit a medical claim:

- Obtain a claim form and complete the Member's portion of the claim form (including your name and Social Security number, the patient's name, and the patient's date of birth);
- Have your physician either complete the Attending Physician's Statement section of the claim form (including

date of service, CPT-4 code [the procedure code], ICD-9 [the diagnosis code], billed charge, number of units [for anesthesia and certain other claims], the provider's federal taxpayer identification number [TIN], billing name and address of the provider and if treatment is due to an accident, the accident details); or submit a completed Claims Administrator-provided claim form (as an alternative, an HCFA [Health Care Finance Administration] health insurance form may be used) or a HIPAA-compliant electronic claims submission; and

- Attach all itemized hospital and doctor's bills and any doctor's statements that describe the services rendered. (In most circumstances, the hospital will submit these claims directly to the address listed in this section for the payment of its bill.)

Claims For Out-Of-Network Benefits

File claims for Out-of-Network medical benefits by sending your claim to the address on the back of your Cigna ID card.

File claims for Out-of-Network prescription drug benefits to the address on the back of your CVS Caremark ID card.

File claims for Out-of-Network dental benefits to Aetna Dental, P.O. Box 14094, Lexington, KY 40512-4094.

File claims for Out-of-Network vision benefits to First American Administrators, Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111.

The Prescription Drug Program

You do not need claim forms when visiting a pharmacy that participates in the CVS Caremark Network. Simply present your ID card and your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not considered a claim under these procedures.

Also, if you obtain a prescription from an Out-of-Network pharmacy and you wish to request reimbursement, you will be required to file a claim form. See page 39.

Pharmacy Coverage

To apply for reimbursement for the cost of denied network pharmacy claims or for the cost of Out-of-Network claims, calling CVS Caremark Customer Care for a claim form or you may download a form from www.caremark.com.

Notice Of Decision

You will be provided with written notice of the decision on your claim. If your claim is denied (whether in whole or in part), this notice will state:

- The specific reason for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeals procedures (including voluntary appeals, if any) and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical basis for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notifications.

NOTE

For Urgent Care Claims and Non-Urgent Pre-Service Claims, you will receive notice of the care that will be covered by the Plan.

Claim Appeal Procedures

Cigna and Cigna Behavioral Health maintain a two-level appeal procedure. If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Claims Administrator responsible for making the initial determination within 180 days after you receive notice of denial. Appeals should be made to the address indicated on the notice you receive from the Claims Administrator. Appeals involving Urgent Care Claims may be made orally by calling the applicable Claims Administrator at the number listed on the back of your ID card.

CVS Caremark also maintains a two-level appeal procedure. CVS will make a decision on a Pre-Authorization request for a coverage determination within 15 days of receiving the request. CVS Caremark will make a decision on a post service claim within 30 days of receiving the request.

If you request a review for a claim's denial due to an assertion that you or your dependents were not eligible for a benefit, such a request should be made to:

Board of Trustees
MILA Managed Health Care Trust Fund
111 Broadway, Suite 502
New York, NY 10006-1901
Telephone number: 212-766-5700
Fax number: 212-766-0844/0845
E-mail: info@milamhctf.com

Review Process

You have the right to review documents relevant to your claim. A document, record or other information will be considered relevant if:

- It was relied upon by the Claims Administrator in making the decision;

- It was submitted, considered or generated (regardless of whether it was relied upon);
- It demonstrates compliance with the Claims Administrator'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 Claims Administrator on your claim, without regard to whether their advice was relied upon in deciding your claim.

Your claim will be reviewed by a different person from the one 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 (such as a determination that the treatment or service was not medically necessary or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing Of Notice Of Decision On Appeal

Urgent Care Claim

You will be provided with a decision over the telephone on review within 72 hours of receipt of the appeal and then you will be sent a written notice.

Non-Urgent Pre-Service And Concurrent Claims

- One-Level Appeals Procedure: Where the Claims Administrator maintains a one-level appeals procedure, you will be sent a notice of decision on review within 30 days of receipt of the appeal.

- **Two-Level Appeals Procedure:** Where the Claims Administrator maintains a two-level appeals procedure, you will be sent a notice of decision on review within 15 days of receipt of the appeal. If more time or information is required to make a decision, the Claims Administrator will specify what additional information is required and it may request up to an additional 15 days.

If you are dissatisfied with the outcome of your first appeal, you may file another appeal with the applicable Claims Administrator within 180 calendar days from the date on the notice of the letter denying your first appeal. You will be sent a notice of decision on review of your second appeal within 15 days from receipt of the second appeal.

Post-Service Claim

- **One-Level Appeals Procedure:** You will be sent a notice of decision on review within 60 days of receipt of the appeal.
- **Two-Level Appeals Procedure:** You will receive a notice of decision on review within 30 days of receipt of the appeal.

If you are dissatisfied with the outcome of your first appeal, you may file another appeal with the applicable Claims Administrator within 180 calendar days from the date on the notice of the letter denying your first appeal. You will be sent a notice of decision on review of your second appeal within 30 days from receipt of the second appeal.

Post-Service Appeals Of Eligibility Which Are Not Related To Specific Medical, Behavioral Health Or Prescription Drug Claims

Ordinarily, decisions on such types of eligibility appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once

a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

Notice Of Decision On Review After Appeal

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- 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;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical basis for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Limitation On When A Lawsuit May Begin

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than two years after the end of the year in which services were provided.

SECTION VI

Your Rights Under ERISA

Your Rights Under ERISA 96



NATIONAL HEALTH PLAN

Your Rights Under ERISA

As a participant in the MILA National Health 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:

- Examine, without charge, at the MILA Managed Health Care Trust Fund office (111 Broadway, Suite 502, New York, NY 10006-1901) and at other specified locations, such as worksites and union halls, all documents governing the Plan, including the Plan, insurance contracts (if any), collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including the Plan, insurance contracts (if any), collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan's annual financial report. MILA is required by law to furnish each participant with a copy of this summary annual report.

You are entitled to continue health care coverage for yourself, your spouse or your 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. You should review this book and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

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" 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 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.

Under ERISA, there are steps you can take to enforce your rights. For instance, if:

- You request materials from the Fund 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 Fund 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 Plan administrator.
- 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 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 entity 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.

If you have any questions about the 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 Fund, 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, DC 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.

SECTION VII

Administrative Information

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NATIONAL HEALTH PLAN

ADMINISTRATIVE INFORMATION

OFFICIAL PLAN NAME	MILA NATIONAL HEALTH PLAN	
Employer Identification Number (EIN)	13-3968546	
Plan Number	501	
Plan Year	January 1 through December 31	
Type of Plan	Welfare	
Funding of Benefits	The Plan is funded solely through employer contributions and the benefits are not insured. In addition, the Plan receives monies from the federal government in partial offset of its cost to provide prescription drug benefits for retirees who are entitled to benefits under Medicare but who are not enrolled in Part D.	
Trust	MILA Managed Health Care Trust Fund 111 Broadway, Suite 502, New York, NY 10006-1901 212-766-5700	
Plan Administrator	MILA Managed Health Care Trust Fund 111 Broadway, Suite 502, New York, NY 10006-1901 212-766-5700	
Plan Sponsor	MILA Managed Health Care Trust Fund 111 Broadway, Suite 502, New York, NY 10006-1901 212-766-5700	
Trustees	As listed on page i	
Agent for Service of Legal Process	LaVerne Thompson, Executive Director MILA Managed Health Care Trust Fund 111 Broadway, Suite 502, New York, NY 10006-1901 212-766-5700	
Claims Administrators	Medical:	Cigna Health and Life Insurance Company P.O. Box 182223, Chattanooga, TN 37422-7223
	Mental Health and Substance Use:	Cigna Health and Life Insurance Company P.O. Box 182223, Chattanooga, TN 37422-7223
	Prescription:	CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136
	Dental:	Aetna P.O. Box 14094, Lexington, KY 40512
	Vision:	FAA /EyeMed Vision Care LLC Attn: Quality Assurance Dept. 4000 Luxottica Place Mason, OH 45040-7111 Fax: 1-513-492-3259

MILA RESOURCES

MILA Fund Office	111 Broadway, Suite 502 New York, NY 10006-1901 212-766-5700 212-766-0844/0845 (fax) www.milamhctf.com info@milamhctf.com	Mon–Fri, 9 a.m.–5 p.m. (Eastern) 24/7	For answers to questions about your benefits or to request claim forms. To access links to the websites of Claims Administrators.
Cigna	Member Services: 1-800-794-7882 www.myCigna.com	24/7	To contact a care coordinator to obtain approval for medical care or for answers to questions about your medical benefits. To find network physicians, specialists and other medical providers.
To Find Network Providers	<ul style="list-style-type: none"> ■ Call 1-800-794-7882. Or go to www.cigna.com or www.myCigna.com. On the main screen, click on Provider Directory. ■ At the next screen under the column marked Cigna HealthCare, click on Physicians or Hospitals (not Pharmacies). ■ At the third screen, select the Open Access Plus Only listing by clicking in the small circle next to it. Then scroll down and click on either Primary Care Physician (“PCP”) or Specialist. Then click on Continue Search. ■ Entering your address and other information requested on the second screen helps narrow the computer search to providers near you. Then scroll down and click on Continue Search to access the list of providers. 		
To Access Your Personal Medical Information	www.myCigna.com	24/7	To access personalized health care information, such as the status of a claim, you will need a user ID and password.
Cigna Behavioral Health (CBH)/ Member Assistance Program (MAP)	1-800-794-7882	24/7	To talk to a Cigna Behavioral Health Manager. Required before receiving any mental health or substance abuse services.
CVS Caremark	1-866-875-MILA (6452) TDD: 1-800-231-4403 www.caremark.com	24/7	To contact a Pharmacy Benefit Manager for advance approval, to find a participating pharmacy, to request a claim form for an Out-of-Network pharmacy or for answers to questions about your prescription drug benefits.
Aetna	1-877-295-3719 www.aetna.com	24/7 Automated	To talk to a Representative, call between 8 a.m. and 6 p.m. based on your time zone. To check eligibility and claim status or locate an In-Network provider, call or log on to www.aetna.com .
EyeMed	1-866-939-3633 www.eyemed.com	Mon-Sat, 7:30 a.m.–11 p.m. (Eastern) Sun, 11 a.m.–7 p.m. (Eastern)	To locate an In-Network provider, contact www.eyemed.com . Choose “ Select ” network tab, and enter your zip code.

Glossary

Important Terms 102



This section provides brief explanations in non-technical language of important terms used in this Summary Plan Description.

Important Terms	
Term	Definition
Claims Administrator	The vendor that MILA has chosen to administer its health benefits is the Claims Administrator. Cigna is our medical Claims Administrator. Cigna Behavioral Health (CBH) is our behavioral health Claims Administrator. CVS Caremark is our prescription drug Claims Administrator. Aetna is our dental Claims Administrator. EyeMed is our vision Claims Administrator.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a law that requires group health plans to offer continuation health coverage when a Member or dependent is no longer eligible for coverage (for example, if you leave the Plan or if your dependent reaches the maximum age for coverage).
Coinsurance	The percentage of the medical cost that is paid by the Member and by the Plan. For example, if you are covered by the Core Plan and need to stay in the hospital for a medical service, you pay 40% of the "reasonable and customary" charges (after the deductible) and the Plan pays 60%.
Contract Year	The 12-month period beginning on October 1 and ending the following September 30 during which an active Member must receive credited hours necessary for coverage under MILA during the following calendar year. For example, October 1, 2019 to September 30, 2020 is one Contract Year.
Copayment (Copay)	The flat dollar amount you pay for a doctor's office visit, hospital admission, emergency room or urgent care center. You also pay a set copay for prescription drugs. See the Benefit Plan Summaries for specific copay requirements.
Credited Hours	You are eligible for the Core, Basic or Premier plan benefits based on the number of credited hours you receive during the Contract Year (October 1 through September 30).
Deductible	The dollar amount you must pay for medical services, dental services or prescription drugs before the Plan begins paying benefits.
Dental Accident	A sudden, unexpected, and unforeseen identifiable occurrence or event producing, at the time, objective symptoms of a bodily injury. The accident must occur while the person is covered under this Plan. The occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an illness or disease of any kind.
Dental Emergency	Any dental condition that: <ul style="list-style-type: none"> ■ Occurs unexpectedly. ■ Requires immediate diagnosis and treatment in order to stabilize the condition; and ■ Is characterized by symptoms such as severe pain and bleeding.
Dental Occurrence	A period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered person: <ul style="list-style-type: none"> ■ Receives no dental treatment, services, or supplies, for a disease or injury; and ■ Neither takes any medication, nor has any medication prescribed, for a disease or injury.

Term	Definition
Dentist	A legally qualified dentist, or a physician licensed to do the dental work he or she performs.
Dependent	Any of your family members who meet all of the eligibility requirements for coverage outlined in this SPD and the Plan Document. See page 67 for details.
Directory	A listing of all network providers. For an up-to-date list, you can call Cigna, Cigna Behavioral Health, CVS Caremark, Aetna or EyeMed, or visit their websites.
Emergency	Under the Plan, an emergency exists if you believe that the person's condition, sickness or injury is such that failure to receive immediate medical care could put that person's health in serious jeopardy. Examples of an emergency include, but are not limited to, chest pain, stroke, poisoning, serious breathing difficulty, uncontrolled bleeding, unconsciousness and severe burns or cuts.
ERISA	The Employee Retirement Income Security Act of 1974 (ERISA) protects Member's rights under qualified pension and welfare benefit plans.
Generic Drugs	These drugs are the most affordable way for you to obtain quality medications at your lowest copayment level. These drugs contain the same active ingredients and are available in the same strength and dosage as their brand name counterparts.
HIPAA	The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections for Plan participants and portability requirements on qualified benefit plans.
Medically Necessary	Generally, a service or supply furnished by a particular provider is medically necessary if the Plan determines, using generally accepted standards, that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved. See page 26 for more information.
Member	A person who is actively employed under the terms of the USMX-ILA Master Contract or by a participating employer approved for coverage by the MILA Trustees and who is eligible for coverage under one of MILA's benefit plans.
Network Provider	A health care provider that has contracted to furnish services or supplies for a negotiated charge and is included in the Claims Administrator's provider network.
Non-Preferred Brand Drugs	These are brand name drugs that generally can be effectively substituted with a preferred drug from the formulary.
Orthodontic Treatment	Any dental service or supply that is furnished to prevent, diagnose, or correct a misalignment, whether or not for the purpose of relieving pain: <ul style="list-style-type: none"> ■ of the teeth; ■ of the bite; or ■ of the jaws or jaw joint relationship.
Out-of-Network Care	This is a health care service or supply furnished by a health care provider that is not a part of the Claims Administrator's provider network.
Out-of-Pocket Limit	The maximum deductible and coinsurance you pay for covered expenses in a calendar year. If your deductible and coinsurance payments reach this limit, the Plan will pay 100% of the charge for covered expenses for the rest of the calendar year.

Term	Definition
Pensioner	A former Member in the longshore industry who is retired under a local Port longshore pension plan and is eligible for post-employment benefits through MILA.
Plan Year	The Plan year for benefits begins on January 1st and ends on December 31st.
Port Association or Employer Association	A local association comprised of participating employers who employ ILA employees who work under the USMX-ILA Master Contract.
Preferred Brand Drugs	These are brand name drugs that either do not have a generic equivalent or are considered to be an effective alternative under the formulary.
Preventive Care	Care that does not treat a particular condition but is meant to help the patient get and stay healthy. Preventive care includes, but is not limited to, well-child check-ups, immunizations, annual exams, and many cancer screenings, such as mammograms.
Primary Care Physician (PCP)	A family or general practitioner, internist or pediatrician who provides a broad range of routine medical services and refers patients to specialists, hospitals and other providers, as necessary. An OB/GYN is considered a PCP when providing routine care. Each covered family member may choose his/her own PCP from the Claims Administrator's provider network.
Qualified Domestic Relations Order (QDRO)	Any judgment, decree or order that provides for child support, alimony, and/or marital property rights to a spouse, former spouse, child or other dependents under a state domestic relations law.
Reasonable and Customary Charges (R&C)	These are the fees determined from claims data to be the appropriate charge in your geographic area for a particular service or supply. If you use Out-of-Network providers, benefits may be based on reasonable and customary charges. See page 27 for more information.
Specialist	A provider whose practice is limited to treating a specific disease, specific parts of the body or specific procedures. Usually (although not always) a specialist is certified as competent to perform by the medical board in his or her specialty. Examples of specialists include, but are not limited to, dermatologists, cardiologists, oncologists, and surgeons.
Transition of Care	If you are currently receiving medical treatment (for example, if you're in the hospital) on January 1st and your MILA benefit plan changes, your benefits will change to the new benefit plan. You have a right under COBRA to pay premiums to continue to receive benefits under your former MILA benefit plan.

