STA-ILA Benefits Trust Fund

Steamship Trade Association of Baltimore, Incorporated

International Longshoremen's Association

STA-ILA Benefits Plan For Active Employees

Summary Plan Description

Amended and Restated
October 1, 2021

STA-ILA BENEFITS TRUST FUND
Holabird Business Park
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Baltimore, Maryland 21224-6514
(410) 633-9311
www.stailafunds.com

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6610 Tributary Street
Baltimore, MD 21224-6514
www.stailafunds.com

October 2021

TO ALL COVERED ACTIVE EMPLOYEES:

The STA-ILA Benefits Trust Fund ("Fund") sponsors the STA-ILA Benefits Plan ("Plan"), which provides supplemental medical benefits to you and your eligible dependents. This supplemental program consists of the following benefits:

- Weekly Accident and Sickness Benefits (Employees Only)
- Life Insurance Benefits (Employees Only)
- Death Benefits (Dependent Spouse/Child Only)
- Accidental Death and Dismemberment Insurance Benefits (Employees Only)
- Dental Benefits
- Vision Benefits
- Substance Abuse Coordinator Services (Employees Only)
- Specialist Reimbursement Account
- Hearing Aid Reimbursement Benefits
- Scholarship Program

The Management-International Longshoremen's Association Managed Health Care Trust Fund ("MILA") provides certain dental and vision benefits to Participants and their Dependents as defined by the MILA eligibility rules. These "supplemental" dental and vision benefits are administered by MILA, and funded by the STA-ILA Benefits Trust Fund to the extent that they are in excess of the standard dental and vision benefits generally provided by MILA. Any questions, concerns, claims, or appeals regarding dental or vision benefits should be addressed to the MILA Plan Administrator.

This Summary Plan Description ("SPD") provides you with an up-to-date description of the benefits available to you and your eligible Dependents from the Plan. This SPD does not contain the provisions of the Agreement and Declaration of Trust under which the Fund operates. The Board of Trustees administers the Fund in accordance with this document.

Your SPD includes a new section called "Life Events." Beginning on page 8, this section explains how your benefits may be affected by certain events (marriage, divorce, retirement, etc.). The language in this brief section has been written to be easily to read and understood, and

avoids any "legalese." We encourage you to refer to this section as a first-step in the event you experience a life-changing event.

We encourage you to contact the Fund Office with any questions you may have concerning your Plan or its administration. The Fund Office personnel will help you identify the rules of the Plan and will refer you to pertinent provisions in this SPD. Only the full Board of Trustees, however, is authorized to interpret the Plan rules, as set forth herein. No Employer, Union, or representative of any Employer or Union acting in such capacity is authorized to interpret this Plan, nor can any person, including Fund Office personnel, act as an agent for the Trustees with respect to questions of interpretation.

Although this Plan is intended to be maintained indefinitely, the Board of Trustees specifically reserves the right to change the Plan's provisions, terminate the Plan, and to add to or delete from the Benefit Schedule provided to active Participants and to the Dependents of such Participants. The Board also reserves the right to adopt new Plan rules and regulations or to modify the existing rules and regulations. Nothing in this SPD or elsewhere should be construed to mean that the Plan's benefits are guaranteed. The Plan will, of course, notify you when significant changes are made effecting the rules, regulations, or Benefit Schedule.

Since the purpose of the Plan is to benefit you and your Dependents exclusively, please read this SPD carefully so that you understand the benefits as well as the eligibility rules and procedures for filing claims. We suggest you keep this SPD and any modifications with your important papers and share it with your Dependents. We also encourage you to visit the Plan's website at **www.stailafunds.com** where you can find information about your benefits and eligibility, forms, such as the Enrollment Card, Address Change Request Form, Weekly Accident and Sickness Claim Form, etc., and important contact numbers.

Sincerely,
BOARD OF TRUSTEES

Disclaimer: Please note that the information presented is for informational purposes only and does not constitute legal, tax, or investment advice. You should discuss any issues you may have with your legal, tax, and other advisors before making determinations and decisions about your specific situation..

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Your STA-ILA Benefits Plan

Your STA-ILA Benefits Plan ("Plan") is a supplemental medical benefits program designed to protect you and your Dependents in time of Illness and Injury. It also is designed to encourage you and your Dependents to stay in good health.

Your Plan provides benefits to you for your supplemental Medically Necessary covered expenses while you are an active Employee and, in certain instances, after you retire under the STA-ILA Pension Plan. Benefits provided for pensioners differ from benefits provided for active Employees. This Summary Plan Description (SPD) describes benefits payable to certain active Group "A" and "B" Employees. Pensioners' benefits are described in the STA-ILA Benefits Plan for Pensioners SPD.

CONTACT INFORMATION	
Fund Office	STA-ILA Benefits Trust Fund Holabird Business Park 6610 Tributary Street Baltimore, MD 21224-6514 (410) 633-9311 (410) 633-9347 Fax
Hearing Aid Reimbursement	Fund Office
Specialist Reimbursement Account	Fund Office
Life, Death & Accidental Death and Dismemberment Benefit	The Hartford Life and Accident Insurance Company One Hartford Plaza Hartford, CT 06155 (860) 392-3802 Fax www.thehartford.com
International Longshoremen's Association	6610 Tributary Street Baltimore, MD 21224-6514 (410) 631-7271
Steamship Trade Association of Baltimore, Inc.	8615 Ridgelys Choice Drive Suite 202 Baltimore, MD 21236-3028 (410) 248-3377

Definitions

There are certain words and phrases used frequently throughout this Summary Plan Description ("SPD") that you should know. They will help you understand your benefits better.

Association

The Steamship Trade Association of Baltimore, Incorporated (STA).

Beneficiary

A person designated by a Participant or the terms of this SPD who is or may be entitled to a benefit from this plan. Beneficiary(ies) shall include Dependents as defined in Section V, Dependents' Eligibility.

Benefits Fund Participation Agreement

An agreement between an Employer and the Union in form and content acceptable to the Board of Trustees that evidences the obligation of the signatory thereto to be bound by the Trust Agreement and the actions of the Board of Trustees.

Calendar Year

The twelve-month period beginning on January 1 and ending on December 31, is used for the purpose of benefit coverage.

Collective Bargaining Agreement

The agreement between an Employer and the Union requiring contributions to the Fund, together with any written modifications, supplements, or amendments thereto which have been accepted by the Trustees as the basis for an Employer's participation in the Fund, as changed from time to time.

Covered Employment

Employment of an Employee by an Employer who is obligated by a Collective Bargaining Agreement (or by a Benefits Fund Participation Agreement as described on page 2) to contribute to the Fund.

Deductible

The amount of out-of-pocket expenses that must be paid each year by an Employee and/or Dependent before any benefits are paid from this Plan.

Dependent, Dependent Child, Dependent Spouse

As defined in Section IV. Dependents' Eligibility.

Disability

Your complete temporary inability to perform substantially all of the duties of your occupation because of a medically determinable physical or mental impairment, as certified by a Physician.

Disability Hours

The hours credited on your behalf for any periods that you are unable to work at your regular occupation because of your Disability. Disability Hours are credited on your behalf according to the rules shown on page 15 of this SPD.

Employee

You are considered an Employee if:

- you work for one or more Employers and the work you perform is covered by the Collective Bargaining Agreement between the Association and the Union in the Port of Baltimore and vicinity;

- you work for one or more Employers, were formerly covered by the Collective Bargaining Agreement, still are working in the longshore industry, and are included in the Plan under a Benefits Fund Participation Agreement between your Employer and the Fund;

- you are an Employee of the Union and the Union has executed the necessary Benefits Fund Participation Agreement authorizing your participation, and the Trustees have accepted this; or

- you are a member of the Fund Office staff of the STA-ILA Pension Fund, STA-ILA Benefits Trust Fund, STA-ILA Severance and Annuity Fund, STA of Baltimore-ILA Container Royalty Fund, or STA-ILA Vacation & Holiday Fund, and there is a Benefits Fund Participation Agreement authorizing your participation in the Fund.

Employer

The following organizations are considered Employers:

- members of the Association who are contributing to the Fund. (Contact the Fund Office to find out whether or not a member of the Association is considered an Employer for purposes of the Plan. If the Association member is considered an Employer, the Fund Office will give you the Employer's address);

- the Union;
- the STA-ILA Pension Fund, the STA-ILA Benefits Trust Fund, and the STA-ILA Severance and Annuity Fund; and
- the STA of Baltimore–ILA Container Royalty Fund and the STA-ILA Vacation & Holiday Fund.

Employment In The Industry

The total amount of time you work as an Employee in Covered Employment.

General Exclusions

Any exclusions that apply to all benefits under the Plan, shown later in this SPD.

Group A Employee

An Employee who received credit for at least 1,000 hours in the previous Plan Year.

Group B Employee

An Employee who received credit for at least 700 hours, but less than 1,000 hours in the previous Plan Year.

Illness

Any bodily sickness or disease, as diagnosed by a Physician and as compared to the person's previous condition.

Incurred

The date on which a service or supply is furnished.

Injury

A wound or damage to the body that is sustained accidentally and by external force.

Medically Necessary

Service or supplies provided by a Physician or other medical provider that are used to treat an Injury or Illness according to standard medical practice, that are directly related to the care or treatment of the Employee or Dependent, and that represent the most appropriate level of care that can be provided safely. A service or supply is not automatically considered "medically necessary" just because it is prescribed by a Physician or other medical provider.

Medicare

The insurance program established by Title XVIII of the Social Security Act of 1965, as originally enacted and subsequently amended.

Non-Occupational Injury

An accidental bodily Injury not arising out of or in the course of Employment.

Non-Occupational Illness

A sickness or disease for which a person is not entitled to benefits under any worker's compensation law.

Participant

An Employee or Dependent who has satisfied the Plan's eligibility requirements and who has actually enrolled in the Plan.

Physician or Provider

A doctor or oral surgeon licensed to practice medicine or perform surgery under the laws of the state where such services are performed, and who is acting within the scope of his license. A duly licensed practitioner who, under the supervision of a Physician, performs services that would be covered under this Plan if performed by the Physician is also treated as a "Physician."

Plan

The STA-ILA Benefits Plan for Active Employees, as amended from time to time.

Plan Year

The 12-month period beginning on October 1 and ending on September 30, used for purpose of eligibility.

Provider

A physician, other health professional, who is licensed or certified under applicable state and federal law to provide covered health care services to you.

Spouse

Your legally married spouse, as determined by applicable state law and federal law.

Union

The Baltimore District Council of the International Longshoremen's Association (ILA).

Introduction

As a covered Employee, you become a Participant in the Plan and are entitled to benefits once you satisfy the eligibility requirements and enroll in the Plan. Generally, to be eligible to participate in this Plan, you must work in a job that is covered under a Collective Bargaining Agreement between the Union and an Employer, which requires contributions to be made to this Plan on your behalf. However, you are also considered a covered Employee if you work in a job that is not covered by a Collective Bargaining Agreement and your Employer has signed a "Benefits Fund Participation Agreement." The Fund Office will notify you when you become eligible for coverage in the Plan.

The Board of Trustees shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of the Plan, and to determine all questions arising in connection with the administration, interpretation, and application of the Plan, including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any Plan document and any determination of fact adopted by the Board of Trustees shall be final and legally binding on all parties. Any interpretation, determination, or other action of the Board of Trustees shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion.

Life Events

As you experience certain "life events" (listed below), it's important to understand how your supplemental benefits through the STA-ILA Benefits Plan are affected.

Your supplemental benefits include:

- Weekly Accident and Sickness Benefits
- Life Insurance Benefits
- Death Benefits
- Accidental Death and Dismemberment Insurance Benefits
- Dental Benefits
- Vision Benefits
- Substance Abuse Coordinator Services
- Specialist Reimbursement Account
- Hearing Aid Reimbursement Benefits
- Scholarship Program

You or one of your dependents should contact the Fund Office by calling 410- 633-9311 if you experience any of the following:

- You get married
- You get divorced or legally separated
- You want to enroll your dependent child
- You do not earn enough hours to maintain your eligibility
- You enter the armed forces
- You become disabled
- You retire
- Your Spouse or Child dies

Benefits Through MILA

Remember, your medical, hospitalization, prescription drug, and primary dental, vision, and hearing aid coverages are provided through the Management-International Longshoremen's Association Managed Health Care Trust Fund ("MILA"). For information about how those benefits are affected when you experience a life event, please contact the MILA Plan Administrator.

- You die

The Plan defines Spouse as a same or opposite-sex person to whom you are legally married.

If You Marry

If you get married while a Participant in the Plan, your spouse is eligible to enroll for coverage. Contact the Fund Office at (410) 633-9311 within 60 days of the date of your marriage.

Coverage for your spouse will begin on the later of the date of your marriage or the first day of the month following the month in which you provide the Fund Office with the required documentation:

- Your marriage certificate;
- Your spouse's birth certificate; and
- Your spouse's Social Security card.

When you add a dependent to your coverage, you will need to update your Enrollment Card and Designation of Beneficiary form at the Fund Office. Your Enrollment Card contains the names and birthdates of your dependents, and the Designation of Beneficiary form contains the name(s) of the beneficiary(ies) who would receive your Life Insurance Benefit.

You may also wish to name your new spouse as your Life Insurance beneficiary. Contact the Fund Office for the appropriate form.

If your Dependent Spouse dies while you are covered by the Plan, you will be eligible to receive a Death Benefit. To receive this benefit, your Spouse's name must be on file at the Fund Office. Refer to page 37 of this Summary Plan Description ("SPD") for details.

If You Divorce or Legally Separate

If you divorce or legally separate, you must contact the Fund Office within 60 days of the effective date. Your spouse will no longer be eligible for Plan coverage if you divorce, but may be eligible to purchase COBRA Continuation Coverage for up to 36 months. He or she should contact the Fund Office at (410) 633-9311 to enroll.

You may still cover an eligible Dependent even if you do not provide more than half of the child's support provided that:

- you and the child's other parent are: (1) divorced or legally separated under a decree of divorce or separate maintenance; (2) separated under a written separation agreement; or (3) live apart at all times during the last six months of the calendar year;

- you and the child's other parent provide over half of the child's support;
- the child is in the custody of one or both of his or her parents for more than half of the year; and
- the child meets all other required eligibility criteria.

Whenever you add a Dependent or have a change in status, it is a good idea to review your beneficiary designation. Contact the Fund Office to make sure your beneficiary information is up-to-date.

If you covered a stepchild but get divorced, the stepchild will no longer be eligible for coverage under this Plan unless it is required by a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order, judgment, or decree that recognizes that an alternative recipient may be entitled to benefits under this Plan in the event of a divorce or other family law action. Orders must be submitted to the Fund Office to determine whether the order is a QMCSO as required under federal law.

If You Add a Child to Your Family

If you have a baby, adopt a child, or acquire a child through marriage, he or she may be eligible for coverage through this Plan. Contact the Fund Office within 60 days of the child's birth, placement for adoption, or marriage (if applicable). Your Enrollment Card will need to be updated.

Coverage will become effective as of the date of birth, adoption, or placement for adoption. In the case of marriage, coverage will become effective no later than the first day of the month following a request for enrollment.

You will need to provide the child's birth certificate or other proof that is acceptable to the Trustees, and a Social Security card.

If you receive Family and Medical Leave (FMLA) from your employer, you will remain eligible for the Specialist Reimbursement Account and Hearing Aid Reimbursement Benefits during the term of the FMLA leave.

If you move, keep in touch! Be sure to contact the Fund Office at (410) 633-9311 to make sure the address information on file is accurate.

If You Don't Work Enough Hours to Remain Eligible for Coverage

If you lose your eligibility for a calendar year because you did not receive credit for enough hours in the previous plan year, you will be notified by the Fund Office. You may be eligible for up to 36 months of coverage for you and your Dependents through COBRA.

If You Enter the Armed Forces

Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Plan complies with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). This legislation guarantees certain rights to individuals called to active duty in the Armed Forces of the United States.

If you are on military leave for 31 days or less, you will continue to receive Specialist Reimbursement Account and Hearing Aid Reimbursement Benefits for up to 31 days. If you are on military leave for more than 31 days, USERRA permits you to continue your Specialist Reimbursement Account and Hearing Aid Reimbursement Benefits for you and your Dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA, and is concurrent with COBRA.

If You Become Disabled

If you become disabled due to a non-work related injury or illness and you are under the care of a physician, you may be eligible for a Weekly Accident and Sickness Benefit. This benefit will be paid to you as long as you are disabled, to a maximum of 26 weeks per period of disability. This benefit is not available to your covered Dependents; it is an employee-only benefit. You must contact the Fund Office in writing within 90 calendar days after the day the illness or injury occurs.

Continuing Your Eligibility During Disability

You may be eligible to continue your eligibility for certain Plan benefits while you are disabled. The rules for crediting you with disability hours while you are away from work due to an injury or illness are based on whether you are a Group A or Group B Employee at the time of your injury or illness, and whether the injury or illness is related to your occupation. Refer to "Eligibility While Disabled" on page 15 of this Summary Plan Description for details.

If You Retire

When you are ready to retire, you should contact the Fund Office. Your coverage under the Plan for Actives continues for the remainder of the calendar year of your retirement. Depending on the amount of hours contributed on your behalf to the Fund during the Plan Year of your retirement, you and your Dependents may be eligible to continue those benefits for an additional calendar year. The Fund Office will be able to advise you whether your coverage extends for the additional calendar year, and whether you would then become eligible for coverage under the Plan for Pensioners.

If Your Dependent Spouse or Child Dies

This Plan provides a Death Benefit to you if your Dependent Spouse or Dependent Child (under age 26) dies while you are covered under the Plan. Contact the Fund Office within 60 days of the

death of your Dependent Spouse or Child. To receive the Death Benefit, your Dependent Spouse's or Dependent Child's name must be on file at the Fund Office.

If You Die

If you die while you are covered under the Plan, coverage will continue for your eligible Dependents until the end of the calendar year in which your death occurs. Coverage may even extend beyond that period if you were credited with enough hours at the time of your death.
Coverage will continue for your eligible Dependents for an additional 12 months after your earned eligibility period (except for Death, Weekly Accident and Sickness, and Accidental Death and Dismemberment Insurance Benefits), as long as they remain "eligible" Dependents. If your Dependents lose coverage, they may be eligible to continue through COBRA continuation coverage.

Life Insurance Benefit

Your designated beneficiary is eligible for a Life Insurance Benefit from this Plan if you die while you are covered under the Plan. Your beneficiary should contact the Fund Office within 60 days of the date of your death to provide the proper paperwork and to submit a claim for benefits.

If your beneficiary dies before you or if you fail to name a beneficiary, the Life Insurance Benefit is paid to your estate. If your beneficiary is a minor, the Life Insurance Benefit is paid according to the rules established by the insurance company.

Eligibility

Employees

Initial Eligibility

Each Calendar Year (or in some instances, earlier, as described below), your eligibility for benefits depends upon your work record in the previous Plan Year. You are eligible for benefits as a **Group A Employee** in a Calendar Year if you receive credit for at least 1,000 hours of work in the previous Plan Year and you complete an Enrollment Card at the Fund Office to receive benefit coverage. You are eligible for benefits as a **Group B Employee** in a Calendar Year if you receive credit for at least 700, but less than 1,000 hours in the previous Plan Year, and you complete an Enrollment Card to receive benefit coverage.

This Enrollment Card contains the names and birthdates of your Dependents. You will also be asked to designate the Beneficiary(ies) who would receive your Life Insurance Benefits.

If you are eligible, your coverage will begin on the earlier of (1) the beginning of the month that is thirteen (13) months from the month in which you earned your first credited hour during the Plan Year, but no later than the beginning of the Calendar Year, or (2) 90 days from the end of the Plan Year. For example:

- If you earned your first credited hour during October 2020 and earned at least 700 credited hours during the Plan Year ending September 30, 2021, you will have coverage beginning on November 1, 2021.

- If you earned your first credited hour during November 2020 and earned at least 700 credited hours during the Plan Year ending September 30, 2021, you will have coverage beginning on December 1, 2021.

- If you earned your first credited hour during December 2020 and earned at least 700 credited hours during the Plan Year ending September 30, 2021, you will have coverage beginning on December 30, 2021.

- If you earned your first credited hour during January 2021 or after and earned at least 700 credited hours during the Plan Year ending September 30, 2021, you will have coverage beginning on January 1, 2022.

Initial eligibility is illustrated in the following table.

Month You Earned First Credited Hour	Coverage Begins
October 2020	November 1, 2021
November 2020	December 1, 2021
December 2020	December 30, 2021
January 2021 - September 2021	January 1, 2022

Continuing Eligibility

Once you establish your eligibility under this Plan, your eligibility for benefits continues for each Calendar Year as long as you receive credit for the required number of hours in the previous Plan Year. You should contact the Fund Office if you wish to change your Beneficiary designation or there is a change in your family status. If you lose your eligibility for a Calendar Year because you did not receive credit for enough hours in the previous Plan Year, you will be notified by the Fund Office.

Example 1 (For Group A Employees)

If you are credited with 900 hours during the Plan Year between October 1, 2020 and September 30, 2021, you are not eligible for "A" coverage benefits for the 2022 Calendar Year (since you did not get credit for at least 1,000 hours in the 2020-2021 Plan Year). If you then are credited with 1,200 hours during the Plan Year between October 1, 2021 and September 30, 2022, you are eligible for "A" coverage benefits for the 2023 Calendar Year.

Example 2 (For Group B Employees)

If you are credited with 600 hours during the Plan Year between October 1, 2020 and September 30, 2021, you are not eligible for "B" coverage benefits for the 2022 Calendar Year (since you did not get credit for at least 700 hours in the 2020-2021 Plan Year). If you then are credited with 900 hours during the Plan Year between October 1, 2021 and September 30, 2022, you are eligible for "B" coverage benefits for the 2023 Calendar Year.

Special Eligibility Rules for Calendar Year 2021

The Trustees are aware of the impact of the COVID-19 pandemic on all of the Fund's Participants and Dependents. Consequently, notwithstanding the Continuing Eligibility rules in this section, the following rules apply if you had a reduction in your 2020 work hours from the previous Plan Year as a result of COVID-19, which caused you not to meet the hours requirements for continuing eligibility. The following special eligibility rules apply for calendar year 2021 only.

If you are not eligible for coverage under the Plan and you worked or were credited with at least one hour of service in the period from October 1, 2019 through September 30, 2020, you shall be entitled to coverage under the Plan for calendar year 2021. You will receive the same level of coverage (Group A or Group B) to which you were entitled in calendar year 2020, unless the number of hours you worked or were credited with in the Plan Year ending September 30, 2020, entitles you to a higher level of coverage in 2021.

Crediting Hours

The number of hours you are credited with during a Plan Year depends on how you are paid and on your status as an Employee covered by the Plan. While actively at work, you will be credited with hours as follows:

Bargaining Unit Employees

If you work for an Employer who is a member of the Association in work covered by the Collective Bargaining Agreement, you receive credit for the number of hours for which you are paid.

Non-Bargaining Unit Employees

If you work for an Employer in a job that is not covered by the Collective Bargaining Agreement and your Employer has signed a "Benefits Fund Participation Agreement," you receive credit for 40 hours per week plus any paid overtime.

Delegates or Officers of the Union and Members of the Fund Office Staff of the STA of Baltimore-ILA Container Royalty Fund

If you belong to this group of Employees, you receive credit on the basis of 1,602 hours per Plan Year or 133.5 hours per month with these organizations, provided your Employer advises the Fund that you are an Employee and makes contributions to the Fund on the basis of these hours.

Eligibility While Disabled

The rules for crediting Disability Hours while you are away from work due to an Injury or Illness are based on whether you are a Group A or Group B Employee at the time of Injury or Illness, and whether the Injury or Illness is related to your occupation, as follows:

For Group A Employees

Occupational Injury or Illness – You receive credit for 20 Disability Hours per week, up to a maximum of 1,000 hours per Plan Year, while you are being paid workers' compensation benefits because you are unable to work in Covered Employment and are receiving temporary total or temporary partial disability (as defined under the workers' compensation laws). These hours will be credited only to the extent necessary to retain Plan A eligibility.

Non-Occupational Injury or Illness – You receive credit for 20 Disability Hours per week, up to a maximum of 1,000 hours per Plan year, while you are unable to return to work because of your Disability. In order to receive credit for Disability Hours while you are away from work because of a Non-Occupational Injury or Illness, and you must provide the Plan with medical proof of your Disability when filing your claim for benefits. These hours will be credited only to the extent necessary to retain Plan A eligibility.

For Group B Employees

Occupational Injury or Illness – You receive credit for 20 Disability Hours per week, up to a maximum of 700 hours per Plan Year, while you are being paid workers' compensation benefits because you are unable to work in Covered Employment and are

receiving temporary total or temporary partial disability (as defined under the workers' compensation laws). These hours will be credited only to the extent necessary to retain Plan B eligibility.

Non-Occupational Injury or Illness – You receive credit for 20 Disability Hours per week, up to a maximum of 700 hours per Plan Year, while you are unable to return to work because of your Disability. To receive credit for Disability Hours while you are away from work because of a Non-Occupational Injury or Illness, you must provide the Plan with medical proof of your Disability when filing your claim for benefits. These hours will be credited only to the extent necessary to retain Plan B eligibility.

Regardless of whether the Injury or Illness is related to your occupation, you must be covered as a Group A Employee or Group B Employee at the time of Injury or Illness to receive credit for Disability Hours, in order to maintain the applicable Group coverage you had at the time of Injury or Illness. Disability Hours credited to your behalf while you have Group B coverage may not be used to elevate your coverage to Group A. You may not use Disability Hours to go from "no insurance coverage" to Group A or Group B coverage.

It is possible that continuing eligibility for coverage may be lost during a period of Illness or Injury.

Example:

You have Plan A coverage for Calendar year 2021 based on hours earned during the October 1, 2019- September 30, 2020 Contract Year. You incur an Illness and begin collecting a Weekly Accident and Sickness Benefit on September 9, 2020. At the time of Illness, you had earned 500 hours during the October 1, 2020- September 30, 2021 Contract Year. The 20 Disability Hours earned during the three weeks before the end of the Contract Year will be insufficient for you to retain coverage for the following Calendar Year. You will, however, continue to collect a Weekly Sickness and Accident Benefit into the 2022 Calendar Year if the Illness persists, even though coverage will have been lost.

Credit Hour Limitation

Disability Hours will be credited for weeks in which you are actually disabled during a period of (a) 156 consecutive weeks if you are being paid workers' compensation benefits during the Disability, or (b) 26 consecutive weeks if you are being paid a Weekly Accident and Sickness Benefit, beginning with the first week of Disability. The maximum number of Disability Hours that can be earned per Plan Year is 1,000 hours for Group A Employees, and 700 for Group B Employees.

Training Hours

You will receive credit for training hours paid or reported by the Association.

Special Rules for Employees of the Fund Office Staff

If you are an Employee of the Fund Office Staff of the STA-ILA Benefits Trust Fund or Pension Fund or Severance and Annuity Fund, you are eligible for coverage under the Plan.

If you are an Employee not already covered by the Plan at the time you become an Employee of the Benefits Trust Fund, Pension Fund, or Severance and Annuity Fund, you will be eligible for Group A Employee coverage on the first day of the month after you have worked for the Fund(s) for one full calendar month.

Your coverage terminates on the last day of the month following the calendar month after termination of your employment. If you are entitled to Pensioners' benefits, such coverage will begin upon termination of Fund Office Staff coverage.

If you are an Employee with either Group A or Group B coverage at the time you are employed by the Benefits Trust Fund, Pension Fund, or Severance and Annuity Fund, your coverage will continue while employed by the Fund(s). If you are an Employee with Group B coverage at the time you are employed by any of the Fund(s), you will be eligible for Group A coverage on January 1 after you have worked at least 1,000 hours in the previous Plan Year.

Termination of Eligibility

Your coverage under the Plan automatically terminates on the earliest of the following dates, unless COBRA Continuation Coverage is elected (*see* page 25):

- the date the Plan is terminated;
- the end of the Calendar Year on which you no longer satisfy the eligibility requirements for Employees;
- the date a claim is paid based on false information given intentionally or fraudulently (coverage will not be resumed until the Fund is fully reimbursed for the improper payments);
- the date your COBRA Continuation Coverage ends (see page 28);
- for you and your Dependents, the date you become entitled to a pension from the STA-ILA Pension Plan. Your Benefit coverage will be continued until the end of the Calendar Year in which you are pensioned. Coverage may be continued for an additional year if you are credited with a sufficient number of hours when you are pensioned. (See the sections of this SPD called "Crediting Hours" (page 14) and "Eligibility While Disabled" (page 15)). When your benefit coverage ends after you are pensioned, you will be eligible for Pensioners' benefits if you have 20 or more pension credits or have retired on a Disability Pension with 15 or more pension credits. If you are pensioned on Early Retirement (age 50-54), you will be eligible for Pensioners' benefits when you reach age 65. If you are pensioned on a Vested Pension and have less than 20 pension credits, you are not eligible for Pensioners' benefits;

- the date of your death.

Reinstatement of Eligibility

If your coverage was terminated because you are no longer employed by a participating Employer, you must again satisfy requirements for initial eligibility for coverage under the Plan.

Dependents' Eligibility

Your eligible Dependents are as follows:

- your lawful Dependent Spouse; or

- your Dependent Child, as follows:

  - your child, whether married or unmarried, including a stepchild, legally adopted child, or a child who is placed with you for adoption, through the end of the month in which the child turns age 26. (Note: In the event you and your spouse divorce, a previously recognized stepchild of a Participant will no longer be considered a stepchild, and coverage will terminate unless otherwise required by a Qualified Medical Child Support Order (QMCSO)).

  - an unmarried child who is appointed by a court to be under your guardianship and is a member of your household.

  - your unmarried child age 26 or older, including a stepchild, legally adopted child or a child who is placed with you for adoption, who meets all of the following requirements: (1) has a permanent physical or mental condition that began prior to age 26 that prevents the child from engaging in any self-sustaining employment; (2) is dependent upon you for over half of his or her support; and (3) is not a "qualifying child" (as defined in the Internal Revenue Code § 152(c)) of any other person, except for the child's other parent in cases of divorce/separation (see the special rule below).

    Special rule in cases of divorce/separation: If you do not provide over half of the child's support, he or she will be an eligible Dependent provided that:

    - you and the child's other parent are: (1) divorced or legally separated under a decree of divorce or separate maintenance; (2) separated under a written separation agreement; or (3) live apart at all times during the last six months of the calendar year;

    - you and the child's other parent provide over half of the child's support;

    - the child is in the custody of one or both of his or her parents for more than half of the year; and

- the child meets all other required eligibility criteria.

The Plan reserves the right to request documentation of Dependent eligibility at any time. Such documentation includes, but is not limited to, marriage certificates, birth certificates, divorce decrees, or tax forms. You may also be required to certify that your dependent(s) meet the Plan's definition of Dependent. The Plan has the right to rely upon this certification unless it has reason to believe that the certification is incorrect. You are also required to notify the Plan if you have any reason to believe that any of your Dependents are not entitled to receive health coverage on a tax-free basis.

Initial Eligibility

For your Dependents to be eligible for coverage under the Plan, you must be an eligible Employee. Coverage for eligible Dependents begins on the latest of:

- the date your coverage becomes effective as described in this Summary Plan Description ("SPD"); or
- the date you acquire the Dependent; or
- the first day of the month following presentation to the Fund Office of all required documentation.

Special Eligibility Rules for Calendar Year 2021

The Trustees are aware of the impact of the COVID-19 pandemic on all of the Fund's Participants and Dependents. Consequently, notwithstanding the Continuing Eligibility rules in this section, the following rules apply if you had a reduction in your 2020 work hours from the previous Plan Year as a result of COVID-19, which caused you not to meet the hours requirements for continuing eligibility. The following special eligibility rules apply for calendar year 2021 only.

If your Dependents are not eligible for coverage under the Plan and you worked or were credited with at least one hour of service in the period from October 1, 2019 through September 30, 2020, your Dependents shall be entitled to coverage under the Plan for calendar year 2021. Your Dependents will receive the same level of coverage (Group A or Group B) to which you were entitled in calendar year 2020, unless the number of hours you worked or were credited with in the Plan Year ending September 30, 2020, entitles them to a higher level of coverage in 2021.

Termination of Eligibility

Coverage for your Dependents automatically ends on the earliest of the following dates:

- the date the Plan is terminated;
- the date that coverage for Dependents under the Plan is terminated;

- the date on which your coverage ends for reasons other than death; or

- the date on which your Dependents cease to satisfy the eligibility requirements for Dependents and/or become eligible as Employees under the Plan.

If you lose eligibility, your Dependent's coverage stops on the date you become ineligible for coverage. However, in certain circumstances, coverage for your Dependents may be extended beyond the date of your death (*see* page 25). If your Dependent ceases to be a Dependent, as defined by the Plan, his or her coverage ends on the first day of the month following the date he or she ceases to be an eligible Dependent, unless he or she has elected COBRA Continuation Coverage.

When your Dependent's coverage is terminated, no payments are made for any expenses Incurred after the date eligibility ceases, even if the condition requiring the treatment began before the coverage ended.

In Case of Death of Eligible Employee

If you die while you are covered under the Plan, coverage shall continue for your eligible Dependents(s) until the end of the Calendar Year in which your death occurs. Coverage may continue for the following Calendar Year if you were credited with enough hours at the time of death to qualify for such coverage. Coverage continues for your Spouse and eligible Dependents for an additional 12 months after your earned eligibility period, with the exclusion of coverage for Death, Weekly Accident and Sickness, and Accidental Death and Dismemberment Insurance Benefits. In any event, coverage may terminate at the end of the applicable period if, at any time during this period, your dependent loses his or her status as an eligible Dependent under the Plan.

In addition, your Dependents may elect to continue benefit coverage after your death. (*See* the "Continuation of Coverage" Section of this SPD on page 25.)

Multiple Eligibility

In the event your covered Dependent independently obtains eligibility as an Employee as described herein, or as a Pensioner under the Plan's Pensioner SPD, he or she shall be entitled to the highest priority of benefit coverage as described in the following paragraph, but shall not be entitled to "multiple" benefit coverage. However, if your Dependent as described in this paragraph has Employee eligibility, the Weekly Accident and Sickness Benefits shall be that which is applicable to his employment status.

For purposes of this Section, Plan A benefits shall be deemed the highest priority of coverage, followed by Plan B benefits, and then by Plan P coverage as provided for in the Plan's Pensioner SPD. This section does not apply to Life Insurance Benefits.

Qualified Medical Child Support Orders

If a court or state administrative agency has issued an order with respect to health care coverage for your Dependent Child(ren), the Plan or its designee will determine if the court or state

administrative order is a Qualified Medical Child Support Order (QMCSO), as defined by federal law. The Plan will notify the parents of each child and advise them of the Plan's procedures that must be followed to provide coverage to the Dependent Child(ren). However, no coverage will be provided for any Dependent Child pursuant to a QMCSO unless all of the Plan's requirements for coverage of that Dependent Child have been satisfied. If you have questions about QMCSOs, or you would like a copy of the Plan's QMCSO procedures free of charge, please contact the Fund Office.

HIPAA Special Enrollment Rights

This Plan complies with the special enrollment rights provided under the Health Insurance Portability and Accountability Act (HIPAA). If you are eligible for benefits and you acquire a new Dependent as a result of birth, adoption, or placement for adoption, you may request enrollment for yourself and your Dependents within sixty (60) days after the birth, adoption, or placement for adoption. Coverage will become effective as of the date of birth, adoption, or placement for adoption.

If you are eligible for benefits and you acquire a new Dependent as a result of marriage, you may request enrollment for yourself and your Dependents within sixty (60) days after the marriage. Coverage will become effective as of the later of the date of marriage or the first day of the month following the month in which you provide the Fund Office with the required documentation.
In addition, if you declined coverage for yourself or your Dependents because of other health insurance or group health coverage, and you lose that coverage as a result of loss of eligibility or termination of employer contributions toward coverage, you may enroll yourself and your Dependents in this Plan provided that you request enrollment within sixty (60) days after your or your Dependents' other coverage ends (or after your employer stops contributing toward the other coverage) and provided you meet all of the eligibility requirements described in Section IV of this SPD. Coverage will become effective no later than the first day of the month following a completed request for enrollment.

If you and/or your Dependents decline coverage under this Plan because you and/or your Dependents are covered under either the State Children's Health Insurance Program ("CHIP") or under Medicaid and you lose eligibility for this coverage or you become eligible for financial assistance under either of these programs, you and your Dependents may be able to enroll in the Plan so long as you and your Dependents otherwise satisfy all the eligibility requirements described in this SPD. If you request enrollment in the Plan within 60 days of losing coverage under CHIP or Medicaid or becoming eligible for financial assistance, coverage will be effective retroactive to the date CHIP or Medicaid coverage terminated or financial assistance was granted.

To request special enrollment in the Plan, contact the Fund Office at the phone number listed on the front of this SPD.

Continuing Eligibility During Leaves of Absence

Family and Medical Leaves of Absence

If you receive a Family and Medical Leave of Absence (FMLA) from your employer, you can continue your Specialist Reimbursement Account and Hearing Aid Reimbursement Benefits offered through the Plan.

The Plan will maintain the Employee's eligibility status until the end of the FMLA leave, provided the contributing Employer properly grants the leave under the FMLA and the contributing Employer makes the required notification to the Fund Office. Call your Employer to determine whether you are eligible for FMLA leave.

Leaves of Absence for Military Service

If you are on military leave for 31 days or less, you will continue to receive Specialist Reimbursement Account and Hearing Aid Reimbursement Benefits for up to 31 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on military leave for more than 31 days, USERRA permits you to continue your Specialist Reimbursement Account and Hearing Aid Reimbursement Benefits for you and your Dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA. *See* page 25 for a full explanation of the COBRA coverage provision. In addition, your Dependent(s) may be eligible for health care coverage under TRICARE, the military health care system. This Plan will coordinate coverage with TRICARE.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from "service in the uniformed services," your full eligibility will be reinstated on the day you return to work or apply to return to work with a Participating Employer, provided that you return to employment:

- within 90 days from the date of discharge if the period of service was more than 180 days; or

- within 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or

- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

Questions

If you have any questions about taking a leave, please speak directly with your Employer. If you have any questions about how a leave of absence affects your benefits, please contact the Fund Office. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

No Retroactive Cancellation of Coverage

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.

Enrollment

In addition to the eligibility requirements described in the preceding sections, an Enrollment Card for benefits coverage must be filed with the Fund Office.

You must file an Enrollment Card in order to be eligible for Employee coverage. You must appear in person at the Fund Office to fill out the card. Among the required information is the name of the Beneficiary you wish to name to receive your Life Insurance Benefits and the names of your Spouse and Dependent Child(ren), and all Social Security cards.

To enroll your Spouse, you must provide a marriage and birth certificate, and a Social Security card. To enroll a Dependent Child, you must provide a birth certificate or other proof that is acceptable to the Trustees, and a Social Security card. In all cases, Social Security cards must be provided.

If, after you have signed an Enrollment Card, your family status changes because of marriage, birth of a child, death, etc., you must notify the Fund Office within sixty (60) days of the applicable event. Upon receipt of the appropriate documents, such as marriage certificates, birth certificates, etc., the Fund Office will adjust your records accordingly.

Although you generally must appear in person at the Fund Office to fill out the Enrollment Card, if you satisfy the hours requirement in a Plan Year for eligibility in the succeeding Calendar Year but die before appearing at the Fund Office to complete the Enrollment Card, your Spouse will be permitted to fill out the Enrollment Card and provide the required information.

COBRA Continuation Coverage

When You May Be Entitled to COBRA Coverage

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you and your eligible Dependents may continue the same Dental Benefits, Vision Benefits, Specialist Reimbursement Account Benefits, and Hearing Aid Reimbursement Benefits temporarily at your own expense, where coverage otherwise would end due to a "Qualifying Event." Under the law, only "Qualified Beneficiaries" are entitled to elect COBRA continuation coverage. Depending on the type of Qualifying Event, a Qualified Beneficiary can include an employee, and his or her Spouse and Dependent(s) who were covered by the Plan when a Qualifying Event occurs. A child who becomes a Dependent Child by birth, adoption, or placement for adoption with the Employee during a period of COBRA continuation coverage is also a Qualified Beneficiary. A person who becomes your Spouse during a period of COBRA continuation coverage is not a Qualified Beneficiary.

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.

If you choose COBRA continuation coverage, you and your Dependents may continue the same Dental Benefits, Vision Benefits, Specialist Reimbursement Account Benefits, and Hearing Aid Reimbursement Benefits that you had prior to the Qualifying Event. COBRA does not cover the Weekly Accident and Sickness, Accidental Death and Dismemberment Insurance Benefits, or Life Insurance Benefits.

Please note that this COBRA continuation coverage is in lieu of the Plan's supplemental medical benefit program for pensioners (also known as the STA-ILA Benefits Plan for Pensioners (the "Pensioner Plan")). If you are eligible for and elect the Pensioner Plan instead of COBRA continuation coverage, you will cease to be a Qualified Beneficiary and you will not be entitled to elect COBRA coverage once your COBRA election period expires. However, if you elect the Pensioner Plan and your Spouse or Pensioned Spouse loses that coverage as a result of a Qualifying Event (such as divorce), your Spouse or Pensioned Spouse will have the right to extend the Pensioner Plan under COBRA with a maximum coverage period of 36 months measured from the date of that Qualifying Event.

What is a Qualifying Event?

To be eligible to elect COBRA continuation coverage, you or your Dependent must lose coverage due to any one of the following Qualifying Events:

Qualifying Event	Who May Purchase Continuation Coverage?	For How Long?
Voluntary or involuntary termination of your employment (other than by reason of gross misconduct), or loss of eligibility due to a reduction of your work hours	Employee, Dependent Spouse, Dependent Child	Normally 18 months, however, the Trustees have extended this to 36 months
You or your Dependent becomes disabled (as determined by the Social Security Administration) at some time before the 60th day of COBRA continuation coverage and the disability lasts until the end of the 18-month COBRA continuation coverage period	Employee, Dependent Spouse, Dependent Child	Normally 29 months, however, the Trustees have extended this to 36 months
You die	Dependent Spouse, Dependent Child	36 months
You become legally separated or divorced from your Spouse	Dependent Spouse, Dependent Child	36 months
Your child is no longer considered a Dependent under this Plan's definition (e.g., he or she reaches the maximum age limit)	Dependent Child	36 months

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Co-Administrator determines that your employment has been terminated, your hours have been reduced so that you are no longer eligible for coverage under the Plan, or you have died. However, you or your family should also notify the Plan Co-Administrator promptly if such a Qualifying Event occurs in order to avoid confusion over the status of your Plan coverage in the event there is a delay or oversight in providing that notice.

You Must Give Notice of Some Qualifying Events

For all other Qualifying Events (your divorce or legal separation from your Spouse, or your Dependent Child losing Dependent status under the Plan), you must notify the Plan Co-Administrator no later than sixty (60) days after the Qualifying Event occurs. The notice of occurrence of any of these events must be provided to the Plan Co-Administrator in writing by using the Plan's "COBRA Event Notice Form for Covered Employees and Qualified Beneficiaries" (hereinafter, "Notice Form") to provide notice to the Plan Co-Administrator. This form may be obtained by contacting the Fund Office.

If you have any questions about how to provide a written notice of a Qualifying Event or other events, please contact the Plan Co-Administrator. **Failure to provide notice within the form and timeframe described above may prevent you and/or your Dependents from obtaining or extending the COBRA continuation coverage.**

How is COBRA Coverage Provided?

Within 30 days after the Plan Co-Administrator determines or receives notice that a Qualifying Event has occurred, the Plan Co-Administrator will then provide you and/or your Dependents with notice of the date on which your coverage under the Plan will end, and the information and election form that you will need in order to elect COBRA continuation coverage. Under the law, you and/or your Dependents will then have only 60 days from the later of the date you ordinarily would have lost coverage because of one of the Qualifying Events described above, or the date you and/or your Dependents received the notice, to apply for COBRA continuation coverage.

If you and/or any of your dependents do not choose COBRA continuation coverage within sixty (60) days after the qualifying event (or, if later, within sixty (60) days after receiving that notice), you and/or they will lose the right to elect COBRA continuation coverage.

Each Qualified Beneficiary has an independent (separate) right to elect COBRA continuation coverage. COBRA continuation coverage may be elected for some members of the family and not others. In addition, one or more Dependents may elect COBRA even if the Employee does not elect it. However, in order to elect COBRA continuation coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event or became an eligible Dependent by marriage, birth, adoption, or placement for adoption during the period of COBRA continuation coverage. An Employee may elect COBRA continuation coverage on behalf of his or her Spouse and a parent may elect or reject COBRA continuation coverage on behalf of a Dependent Child living with him or her.

In considering whether to elect COBRA continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within thirty (30) days after your Plan coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Payment for COBRA Coverage

You are responsible for the entire cost of COBRA continuation coverage and can pay for the coverage on a monthly basis. When you and/or your Dependents become entitled to this coverage, the Plan Co-Administrator will notify you of the COBRA premium amounts that you must pay. Individuals who continue full coverage under COBRA pay 102% of the Plan's cost, even though the law permits a plan to charge up to 150% of cost under certain conditions.

If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. However, the first COBRA payment must be sent to the Plan Co-Administrator not later than 45 days after the date you elect the COBRA continuation coverage. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA in full within this timeframe, you will lose all COBRA continuation coverage rights under the Plan.

Payments for subsequent months are due on the first day of the month for which coverage is provided. The Fund Office will bill you on a monthly basis for subsequent months.

Grace Period for Payments

Although payments are due on the first day of the month, you will be given a grace period of thirty (30) days after the first day of the coverage period to make each payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make your payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

Maximum Coverage Period

The maximum time period for COBRA continuation coverage normally depends upon the Qualifying Event that causes the termination of coverage. Although not required by law, the Board of Trustees has decided to extend the Plan's maximum period of COBRA Continuation Coverage for up to 36 months for all Qualifying Events. Please refer to the "What is a Qualifying Event?" for a list of these Qualifying Events. In no event will a COBRA continuation coverage period be longer than a total of 36 months.

Special Enrollment Rights

If while you are enrolled for COBRA continuation coverage you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Dependent for coverage for the balance of the period of COBRA continuation coverage by doing so within **30 days** after the marriage, birth, adoption, or placement for adoption. Notice is to be provided to the Plan Co-Administrator by using the Plan's Notice Form, available from the Fund Office.

Any Qualified Beneficiary can add a new Spouse or child to his or her COBRA continuation coverage. However, the only newly added family members who have the rights of a Qualified Beneficiary, such as the right to extend a COBRA continuation coverage period in certain circumstances, are children born to, adopted, or placed for adoption with the Employee.

If while you are enrolled for COBRA continuation coverage, your Dependent(s) lose coverage under another group health plan, you may enroll that Dependent for coverage for the balance of the period of COBRA continuation coverage by doing so within thirty (30) days after the termination of the other coverage. Notice is to be provided to the Plan Co-Administrator by using the Plan's Notice Form, available from the Fund Office.

In order to be eligible for this special enrollment right, the Dependent must have been eligible for coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the Dependent must have been covered under another group health plan or had other health insurance coverage. The loss of coverage must be due to loss of eligibility under another plan, including, but not limited to, termination of employment, termination of employer contributions, or exhaustion of COBRA continuation coverage under another plan. Loss of

eligibility does not include a loss of coverage due to failure of the individual or participant to pay premiums on a timely basis or termination of employment for cause. **Adding a Dependent may cause an increase in the amount you must pay for COBRA Continuation Coverage.**

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event, but the Plan Co-Administrator determines that an individual is not entitled to the requested COBRA continuation coverage, the individual will be sent an explanation indicating why the COBRA continuation coverage is not available. This notice of the unavailability of the COBRA continuation coverage will be sent according to the same timeframe as a COBRA election notice.

Early Termination of COBRA Coverage

COBRA continuation coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- all required payments are not made on time;
- the person receiving the coverage becomes covered by another group health plan;
- the Plan is terminated, or otherwise does not provide group Dental Benefits, Vision Benefits, Specialist Reimbursement Account Benefits, and Hearing Aid Reimbursement Benefits; or
- the Employer that employed you prior to the Qualifying Event has stopped contributing to this Plan, but is making group health plan coverage available through another health plan. You should contact your former employer to determine whether it will assume your COBRA continuation coverage.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Dependent not receiving continuation coverage (such as fraud).

Once your COBRA coverage terminates, it cannot be reinstated. You and your eligible Dependents can only become covered under the Plan again if you return to Covered Employment and meet the eligibility requirements.

Notice of Early Termination of COBRA Coverage

The Plan Co-Administrator will notify a Qualified Beneficiary if COBRA continuation coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA continuation coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period and the date COBRA continuation coverage terminated. The notice will be provided as soon as practicable after the Plan Co-Administrator determines that COBRA continuation coverage will terminate early.

Confirmation of COBRA Coverage to Providers

Under certain circumstances, federal rules require the Plan to inform your health care providers as to whether you have elected and/or paid for COBRA continuation coverage. This rule only applies in certain situations where the provider is requesting confirmation of coverage and you are eligible for, but have not yet elected, COBRA continuation coverage, or you have elected COBRA continuation coverage but have not yet paid for it. In these circumstances, the providers will be given the status of the election and/or payment, and will be given notice that no claims will be paid until the amounts due have been received. They also will be informed that COBRA continuation coverage will terminate effective as of the date of any unpaid amount if payment is not received by the end of the grace period.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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 the Plan or your COBRA continuation coverage rights should be addressed to the Plan Co-Administrator identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 of visit the EBSA website at 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 Marketplace, visit www.HealthCare.gov.

Keep the Plan Informed of Address Changes

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

Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained on request from:
STA-ILA Benefits Plan
Holabird Business Park
6610 Tributary Street
Baltimore, Maryland 21224-6514
(410) 633-9311

You Must Concurrently be a Qualified Beneficiary under MILA's COBRA Rules

Because the Plan's Dental Benefits, Vision Benefits, Hearing Aid Reimbursement Benefits and Specialist Reimbursement Benefits are supplemental to the benefits provided by MILA, in order to be eligible for the Plan's COBRA Continuation Coverage you must concurrently be a Qualified Beneficiary under MILA's COBRA rules.

Weekly Accident and Sickness Benefit

The Plan pays a Weekly Accident and Sickness Benefit in the amount shown in the Benefit Schedule, if you become Disabled because of a Non-Occupational Injury or Illness and you are under the care of a Physician.

The Weekly Accident and Sickness Benefit is provided to eligible Employees only, and is subject to the Subrogation/Indemnification provisions (*see* page 54) of this SPD.

The Fund Office must be notified in writing of an Illness or Injury for which benefits are payable within 90 calendar days after the day the Illness or Injury occurs.

Duration of Benefits

Weekly Accident and Sickness Benefits are payable from the first (1st) day of Disability if your Disability was due to a Non-Occupational Injury, hospital confinement or outpatient surgery. If your Disability was due to a Non-Occupational Illness, Weekly Accident and Sickness Benefits are payable from the sixth (6th) day of your Disability.

If you receive the Weekly Accident and Sickness Benefit for at least five (5) full weeks, the Weekly Accident and Sickness Benefit is payable retroactively for any period of time that such benefit was not initially payable.

If you qualify for the Weekly Accident and Sickness Benefit and your coverage subsequently terminates for any reason, this benefit amount will be paid for as long as you remain Disabled. For each period of disability, your benefits are paid up to a maximum of 26 weeks as long as you remain Disabled.

Period of Disability

A "Period of Disability" is measured from the time you leave work because of your Disability until you recover from the Disability. However, if you return to work after recovering from your Disability and leave work again within two weeks because of a Disability resulting from the same or a related Injury and Illness, the period of Disability that started after your return to work is considered a continuation of the previous period of Disability. If you leave work because of the same or a related Disability after you have been back to work for at least two weeks, a new period of Disability begins. Of course, a new period of Disability begins whenever you leave work for a Disability that is not related to other Disabilities you may have had.

Examination by Physician

You may be required to submit to an examination by a Physician selected by the Plan, and to submit to re-examination at periodic intervals to determine your physical or mental condition.

Special Rule for Voluntary Rehabilitation

Notwithstanding the foregoing, if you are voluntarily admitted to an in-patient alcohol or drug rehabilitation program through the assistance of the Plan's Substance Abuse Coordinator (*see* page 45), and the referral was not related to your failure to pass a drug or alcohol test, or disciplinary action from your Employer such as your suspension or termination from employment, then Weekly Accident and Sickness Benefits are payable for up to four (4) weeks of confinement. If the rehabilitation program provides the Fund Office with a written recommendation for continuing in-patient coverage beyond the four (4) weeks, the Weekly Accident and Sickness Benefit may be extended through the length of the recommended continuous confinement. In no event, however, will any payment of any such Weekly Accident and Sickness Benefit be made for more than eight weeks in total or for more than two instances during your lifetime.

Limitations

Weekly Accident and Sickness Benefits are not payable under any of the circumstances listed in the General Exclusions section of this SPD.

Also, benefits are not payable under the following circumstances:

- while you are receiving a salary from any Employer;
- while you are receiving State of Maryland unemployment benefits;
- as of the day before you start receiving pension benefits from the STA-ILA Pension Plan (unless you are receiving a pension benefit due to the Pension Plan's "Required Beginning Date" provisions);
- if you are not under the care of a Physician (the Physician must certify in writing that you are under his care);
- if your inability to perform substantially all of the duties of your occupation is the result of a permanent medically determinable physical or mental impairment, as certified by a Physician;
- you are deemed permanently disabled by a certified Physician; or
- if your Disability is due to an occupational Injury or Illness.

Life Insurance Benefit

Payment of Life Insurance Benefit

The Plan has contracted with an insurance company to pay the Life Insurance Benefit in the amount shown in the Benefit Schedule to your Beneficiary if you die from any cause while covered by the Plan. If your Beneficiary dies before you or if you fail to name a Beneficiary, the Life Insurance Benefit is paid to your estate. If your Beneficiary is a minor, the Life Insurance Benefit is paid according to the rules established by the insurance company. The Life Insurance Benefit is available only to Employees, not their Dependents. You may not assign the Life Insurance Benefit to any individual or entity.

Designation of Beneficiary

When you enroll as a participant, you will be asked to name a Beneficiary. You may name more than one Beneficiary to receive your Life Insurance Benefit, and you may change your designation at any time by filing a form with the Fund Office.

Conversion Privilege

If an individual's Life Insurance Benefit, or any portion thereof, terminates, he or she is entitled to convert all or a portion of the Amount of Insurance which has been terminated. This conversion will be to an individual policy of life insurance ("Conversion Policy"). The individual will not be required to submit evidence of insurability to convert.

Conversion Rights

If your Life Insurance Benefit, or any portion thereof, terminates because you cease to be eligible or are transferred from one Class another, and the Class to which you are transferred provides lesser benefits, you may convert up to the Amount of Insurance which terminated, less any amount for which you become eligible under the Life Insurance Benefit or under any other group policy within 31 days from the date of termination. If your Life Insurance Benefit is reduced because of age or retirement, you may convert up to the amount of the reduction. If your Life Insurance Benefit terminates because this policy terminates, or is amended to terminate coverage for a Class under which you were insured, you may convert to an amount that does not exceed the lesser of the following, provided you have been continuously insured under the Life Insurance Benefit for at least five (5) years:

- the amount of Life Insurance Benefit in effect on the date of termination, less any amount for which you become eligible under this Policy or any other group policy (which replaces this Policy) within 31 days after the date of termination; or

- $10,000.

Notice of Conversion Privilege

The Plan will notify you of your right to convert. If the notice is not given by the 16th day of the 31-day Conversion Period, you will have an additional period in which to convert. The additional period will expire 15 days from the date you are notified, but in no event will the right to convert be extended more than 91 days beyond the date your insurance terminated. Written notice presented to you, or mailed to your last known address, shall constitute notice for purposes of this provision. In no event is your Life Insurance Benefit extended beyond the end of the 31-day Conversion Period, whether or not notice is given.

Conversion Period, Conversion Policy, Premium, and Effective Dates

To qualify for a Conversion Policy, you must submit a written application to the Life Insurance Company and pay the first premium due within 31 days from the date your Life Insurance Benefit terminates, unless an additional period in which to convert has been granted as shown in *Notice of Conversion Privilege* in this Section.

You may convert to any individual policy that is then being offered by the Life Insurance Company, other than term insurance, or insurance that provides disability or other supplemental benefits.

The premium rates for the Conversion Policy will be the Life Insurance Company's premium rates in effect for the amount and type of policy elected and based on the individual's class of risk and attained age (age nearest birthday at the date of issue of the Conversion Policy) on the effective date of the Conversion Policy. The individual Life Insurance Conversion Policy will take effect at the end of the 31-day period provided the premium has been paid before the end of such period.

Death Within the Conversion Period

If you die during the 31-day Conversion Period, the maximum Life Insurance Benefit that you were entitled to convert will be paid as a benefit under this Policy, to the last Beneficiary named, whether or not conversion was applied for, and premium paid. If a Conversion Policy was applied for, such Conversion Policy will be null and void even if the Conversion Policy had been issued; and no death claim will be payable under the Conversion Policy. The Life Insurance Company will return any premium paid for the Conversion Policy.

Coverage During Disability

If you become totally disabled (as defined by the insurance company) while you are covered by the Plan as an Employee, and you are unable to perform any type of work for wage or profit (as defined by the insurance company), your Life Insurance Benefit coverage continues if you satisfy all of the following conditions:

- you remain totally disabled until the date of your death;
- your death occurs within 12 months after you become totally disabled; and

- your death occurs before you reach age 62.

If you satisfy these conditions, your Beneficiary receives your Life Insurance Benefit if proof of your death and total disability is given to the insurance company within one year after your death.

If your Life Insurance Benefit terminates because of your total disability and you use the conversion privilege to purchase individual coverage, your Beneficiary will only receive a benefit under this section if no claims are made under the conversion policy. The conversion policy must be returned to the insurance company and any premiums paid to the insurance company will be refunded if no benefits have been paid from the conversion policy.

Dependent Spouse or Child Death Benefit

If your Dependent Spouse dies while you are covered by the Plan as an Employee, you shall be paid a Death Benefit in the amount shown in the Benefit Schedule on page 73. The Plan has contracted with an insurance company to pay the Death Benefit for your Spouse, in the amount shown in the Benefit Schedule. If your Dependent Child under the age of 26 dies while you are covered by the Plan as an Employee, you shall be paid a Death Benefit in the amount shown in the Benefit Schedule on page 73. The Death Benefit for your Dependent Child under the age of 26 is self-funded by the Plan. To receive the Death Benefit described in this paragraph, your Spouse's or Dependent Child's name must be on file at the Fund Office.

Accidental Death and Dismemberment Benefit

The Plan pays an Accidental Death and Dismemberment Insurance Benefit for Employees who lose a limb or eyesight within ninety (90) days of a Non-Occupational Injury, as long as the claims procedure described later in this Summary Plan Description ("SPD") is followed. The Plan has contracted with an insurance company to pay this Accidental Death and Dismemberment Insurance Benefit.

Upon receipt of due proof of loss, the Accidental Death and Dismemberment Benefit will be paid if:

- you, while insured under this benefit, suffer an accidental Injury;
- as the direct result of the accident, and independent of all other causes, you suffer a Covered Loss within 90 days after the accident; and
- the accident is not the result of an Injury which arises out of or in the course of any employment with a Contributing Employer.

A "Covered Loss" means permanent loss of:

- life;
- a hand, by complete severance at or above the wrist joint;
- a foot, by complete severance at or above the ankle joint; or
- an eye, involving irrecoverable and complete loss of sight in the eye;

except as excluded under Exclusions in this Section, and subject to all the terms and conditions of this Section. The amount of benefit to be paid for a Covered Loss is as shown in the Benefit Schedule.

If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

Exclusions

No benefit will be paid for any loss that is caused by any of the following:

- bodily or mental Illness or disease of any kind;
- bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound). This exclusion does not apply to bacterial infections contracted by you as the result of being a victim of a crime;

- suicide or attempted suicide while sane or insane;
- intentional self-inflicted Injury;
- your voluntary participation in, or the result of your voluntary participation in, the commission of a felonious assault or felony;
- war or act of war, declared or undeclared; or any act related to war, or voluntary insurrection;
- medical or surgical treatment of an Illness or disease;
- service in the armed forces of any country while such country is engaged in war;
- police duty as a member of any military, naval or air organization;
- a loss sustained or contracted in consequence of your being under the influence of narcotics;
- controlled substances, unless taken as prescribed by a Physician; or
- any poison or gas voluntarily taken, administered, absorbed, or inhaled.

Dental Benefit

Dental Benefit

The Plan offers supplemental Dental Benefits to you and your Dependents in addition to the dental benefit coverage offered by MILA through its designated dental benefit manager. The Plan will pay the difference between the amount paid by MILA's designated dental benefit manager, if any, and the actual cost of the in-network service, up to the maximum benefit payable by the Plan for the covered in-network service. You have the option of using an in-network dental provider designated by MILA's dental benefit manager, or an out-of-network dental provider; however, your out-of-pocket expenses may be lower if you use an in-network dental provider.

The following are the other in-network Dental Benefits provided by the Plan, up to the limits specified in the Schedule of Benefits:

- consultations and oral evaluations
- fluoride treatments every six months until the end of the year in which the covered individual attains age 21
- sealants on permanent molars, once per tooth per three-years, until the end of the year in which the covered individual attains age 21
- composite fillings on all teeth
- porcelain crowns on all teeth
- pulp vitality test every six months
- anesthesia or similar drugs
- FDA-approved and ADA-acceptable dental implants. This benefit includes implant replacements, but only if five years have elapsed since completion of the initial surgical procedure, with the original implant being determined by a dentist to be neither serviceable nor repairable. The Plan's allowance for the implant will include all subsequent maintenance visits as required, as well as cleanings and repair and/or replacement of screws or attachments
- additionally, the Plan will generally reimburse, up to the limits specified in the Schedule of Benefits, in instances where MILA's designated dental benefit manager might exclude coverage under its "missing tooth" exclusion, "less expensive alternative" clause; or "surgically removed erupted tooth" clause.

If you use an in-network dental provider, you will be eligible for covered dental services at a benefit level no less than the amount shown in the Schedule of Benefits, taking into account the benefits received through MILA's designated dental benefit manager. In some instances, MILA's designated dental benefit manager may provide the added benefit in addition to MILA's basic dental benefit, and then invoice the Plan (but not you) for the difference. In instances where MILA's designated dental benefit manager provides only the basic level of MILA's dental benefit, this Plan will then reimburse you for the difference, if any, between the amount of the in-network dental benefit payable by MILA's designated dental benefit manager and the benefit amount that otherwise is payable by this Plan.

In order to receive a reimbursement from the Plan, you or your provider must first submit your claim to MILA's designated dental benefit manager. You may then submit a claim for the difference in benefits to the Fund Office, which must be accompanied with an Explanation of Benefits from MILA's designated dental benefit manager indicating the amount paid by MILA's designated dental benefit manager or the reason for rejection of the claim and proof of payment to the provider. The Fund Office will then consider your claim for supplemental payment and will reimburse you to the extent that your claim is approved. All reimbursement requests must be submitted to the Fund Office within one year of the date of the Explanation of Benefits or claim denial.

If you use an out-of-network dental provider, you will not be eligible for reimbursement from the Plan's Fund Office.

Limitations

- covered services must be performed by or under the supervision of a dentist, within the scope of practice;

- benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures or bridges;

- if you switch dentists during a course of treatment, or if more than one dentist renders services for one dental procedure, benefits shall be limited as if only one dentist rendered the service;

- benefits will be paid only after all dental procedures have been completed (this provision does not apply to Orthodontic Services);

- orthodontic benefits are payable for up to 36 consecutive months of retention treatment provided your Dependent Child remains eligible during this period;

- Dental Benefits are subject to the Subrogation/Indemnification provisions described in the SPD.

The Plan covers in-network services, only to the extent that it provides a higher benefit amount for a covered service than MILA's designated dental benefit manager.

Exclusions

- replacement of a denture, bridges, or crown as a result of loss or theft;
- replacement of an existing denture, bridges, or crown that is determine to be satisfactory or repairable;
- replacement of dentures, bridges, or crowns within five years from the date of placement or replacement for which benefits were paid in whole or in part by the Plan;
- appliance or restorations needed in completed reconstruction where natural teeth are present to increase vertical dimension;
- treatment or services for temporal mandibular joint disorders which is not the result of documented disease, trauma, or congenital deformity;
- gold foil fillings;
- dental services mainly for cosmetic reasons except that benefits will be provided for services required as a result of trauma to whole sound natural teeth;
- splinting;
- night guards;
- prescription drugs.

Other examples of benefits not covered are benefits provided under Titles XVIII and XIX of the Social Security Act, under any workers' compensation or occupational disease act or law, under any employers' liability law, or under any other legislation having a similar purpose, regardless of whether you or your Dependent elects to claim such benefits, or to the extent that the cost of such dental care may be recovered in any action at law and in compromise settlement of such claims against any party other than the insured.

Vision Care Benefit

Vision Care Benefit

The Plan offers supplemental vision coverage to you and your Dependents in addition to the vision benefit coverage offered by MILA through its designated vision benefit manager. The Plan will pay the difference between the amount paid by MILA's designated vision benefit manager, if any, and the actual cost of the in-network service, up to the maximum benefit payable by the Plan for the covered in-network service. You have the option of using an in-network vision provider designated by MILA's vision benefit manager, or an out-of-network vision provider; however, your out-of-pocket expenses may be lower if you use an in-network vision provider.

If you use an in-network vision provider, you will be eligible for covered vision services at a benefit level no less than the amount shown in the Schedule of Benefits, taking into account the benefits received through MILA's designated vision benefit manager. In some instances, MILA's designated vision benefit manager may provide the added benefit in addition to MILA's basic vision benefit, and then invoice the Plan (but not you) for the difference. In instances where MILA's designated vision benefit manager provides only the basic level of MILA's vision benefit, this Plan will then reimburse you for the difference, if any, between the amount of the in-network vision benefit payable by MILA's designated vision benefit manager and the benefit amount that otherwise is payable by this Plan.

In order to receive a reimbursement from the Plan, you or your provider must first submit your claim to MILA's designated vision benefit manager. You may then submit a claim for the difference in benefits to the Fund Office, which must be accompanied with an Explanation of Benefits from MILA's designated vision benefit manager indicating the amount paid by MILA's designated vision benefit manager or the reason for rejection of the claim and proof of payment to the provider. The Fund Office will then consider your claim for supplemental payment and will reimburse you to the extent that your claim is approved. All reimbursement requests must be submitted to the Fund Office within one year of the date of the Explanation of Benefits or claim denial.

If you use an out-of-network vision provider, you will not be eligible for reimbursement from the Plan's Fund Office.

Limitations

- vision care expenses are covered if they are provided by an ophthalmologist, optometrist or optician. Such person must be properly licensed in the state where the services or supplies are provided and be acting within the scope of his license.

- the Plan covers one eye exam, one set of prescription single vision or standard multi-focal lenses, and one set of select frames in each one-year period for each covered person. The Plan also covers one set of contact lenses (in place of one set of lenses and

frames) per year. In addition, the Plan covers two sets of lenses for cataract care within two years of a diagnosis of cataracts.

- the Plan covers in-network services, only to the extent that it provides a higher benefit amount for a covered service than MILA's designated dental benefit manager.

- Vision Benefits are subject to the Subrogation/Indemnification provisions described in the SPD.

Exclusions

Vision Benefits are not payable under any of the circumstances listed in the General Exclusions section of the SPD or if such benefits are covered under any other Section of the Summary Plan Description. Also, benefits are not payable for:

- replacement of lost lenses and/or frames;

- medical or surgical treatment for eye disease which require the services of a Physician;

- non-prescription sunglasses;

- non-prescription goggles (goggles covered under the frame allowance); or

- services and supplies paid for by any other group insurance program.

No payment is made for medical or surgical treatments; drugs or medications; non-prescription lenses; two pair of glasses in lieu of bifocals; subnormal visual aids; vision examination or materials required for employment; replacement of lost, stolen, broken or damaged lenses, contact lenses or frames, except at normal intervals when service would otherwise be available; services or materials provided by Federal, State, local government, or worker's compensation; examination, procedures, training, or materials not listed as a covered service; industrial safety lenses and safety frames, with or without side shields; parts or repair of frame.

Substance Abuse Coordinator Services

The Plan provides benefits in the form of a Substance Abuse Coordinator ("Coordinator"), also referred to as the Drug and Alcohol Director (referred to herein as the "Director/Coordinator"), whose job is to facilitate referrals of Participants to appropriate drug or alcohol facilities, provide advice and act as a conduit with the Substance Abuse program provided by the Management-International Longshoremen's Association Managed Health Care Trust Fund ("MILA") and the collectively bargained STA-ILA Drug and Alcohol Program in the Port of Baltimore. Contact the Director/Coordinator at the STA-ILA Benefits Fund Fund Office at the address and phone number listed on page 1 of this SPD.

The Director/Coordinator, upon notification of positive test results from the collectively-bargained STA-ILA Drug and Alcohol Abuse Program, provides affected Participants with choices for rehabilitation programs best fit to meet their individual needs. The Director/Coordinator is an employee of the STA-ILA Benefits Fund whose sole responsibility is to support eligible Participants in recovery and to assist them with re-entry into the work force.

Benefits Provided through the Director/Coordinator Include:

- facilitating the substance abuse treatment of Participants in accordance with the Substance Abuse Program provided by MILA and the STA-ILA Drug and Alcohol Abuse Program.

- assistance in coordinating A&S benefits for employees entering into treatment or who are in treatment.

- assistance with completing required documents for substance abuse treatment.

- assistance in obtaining medical documents for reinstatement when returning to the workforce.

- research and comparison of rehabilitation facilities to best fit Participant treatment needs.

- assistance to Participants with education regarding employee requirements when under one-year suspension and report to the Drug and Alcohol Committee.

- assistance and facilitating communication between Participants and the Medical Review Officer.

Please note, the Director/Coordinator has no authority regarding suspension or disciplinary actions which are undertaken by Management pursuant to the Collective Bargaining Agreement, as those actions are subject to the Collective Bargaining Agreements' grievance procedures. Participants should direct those inquiries to the STA-ILA Drug and Alcohol Abuse Committee.

Specialist Reimbursement Account

Specialist Reimbursement Account Legal Status

The Specialist Reimbursement Account is intended to be an HRA (health reimbursement arrangement) as defined under IRS Notice 2002-45. In addition, the Specialist Reimbursement Account is intended to be an employer-provided medical reimbursement plan under Code §§105 and 106 and regulations issued thereunder, and to satisfy the minimum value method of integration described in Internal Revenue Service Notice 2013-54 and Department of Labor Technical Release 2013-3, through integration with the non-HRA group health plan of the Management-International Longshoremen's Association Managed Health Care Trust Fund (MILA). This Specialist Reimbursement Account and the applicable non-HRA group health plan shall be interpreted to accomplish these objectives.

Specialist Reimbursement Account Benefit

The Plan will reimburse you and your Spouse for a portion of the co-payment amounts you incur while visiting a "specialist" Physician through your medical coverage with the Management-International Longshoremen's Association Managed Health Care Trust Fund (MILA).

The Plan will reimburse you up to $15.00 of this co-payment amount. In order to receive reimbursement, you must submit your receipts or proof of payment and your Explanation of Benefits (EOB) to the Fund Office. The receipt or EOB must clearly indicate a description and date(s) of services provided, the provider's name and address, and the amount you paid to the provider. The medical service must also be considered a covered specialist claim under the MILA Fund.

All eligible expenses must be submitted for payment by March 31st of the Calendar Year following the Calendar Year in which services were provided.

Suspending Your Specialist Reimbursement Account

A Participant may elect to suspend his or her Specialist Reimbursement Account by submitting an acceptable form to the Fund Office. The Participant's suspension form will remain in effect until: (a) a fixed date, as specified by the Participant; (b) the Participant's death; or (c) the earlier of the two. The Participant may not modify or revoke the election during the period of suspension. The Participant will not receive reimbursements for any specialist visits incurred during the period to which the suspension election applies.

Hearing Aid Reimbursement Benefit

In General

The Plan pays for the purchase and fitting of one hearing aid for each ear once every three years, up to 80% of the first $2,000 of Covered Expense per hearing aid. In order to be initially eligible for this benefit, the Participant must produce a statement from a Physician confirming the necessity for a hearing aid.

Coordination with MILA

All hearing aid benefit claims must first be submitted to MILA's designated hearing aid benefit manager. The Plan will pay the difference, if any, between the amount of hearing aid benefit payable by MILA's designated hearing aid benefit manager and the benefit amount that otherwise would have been payable by the Plan.

For example, if the Plan would have paid $1,600 for a covered hearing aid service and MILA's designated hearing aid benefit manager provides a benefit of $1,500 for the service, then this Plan will pay a benefit of $100. Conversely, if MILA's designated hearing aid benefit manager would have provided a benefit of $1,600 and this Plan provides $1,500 for that service, then there would be no benefit payable by this Plan.

Any request for benefits from this Plan must be accompanied with an Explanation of Benefits from MILA's designated hearing aid benefit manager indicating the amount paid by MILA's designated hearing aid benefit manager or the reason for rejection of the claim.

Limitations

Hearing Aid Expense Benefits are not payable under any of the circumstances listed in the General Exclusions section of this SPD. In addition, benefits are not payable for:

- hearing aid batteries;
- repair of hearing aids; and
- expenses that are covered under any other Section of the Summary Plan Description.

Scholarship Program

Eligibility

Employees, Dependent Spouses, and Dependent Children are eligible to receive a scholarship awarded by the Trustees, provided the Employee has earned a total of ten (10) years of Vesting Service under the STA-ILA Pension Plan. In addition, eligibility to receive or maintain a scholarship award is contingent upon the Employee having earned a Year of Vesting Service in at least two (2) of the last three (3) Contract Years (October 1 to September 30).

The Employee or Dependent eligible for a scholarship award must either be enrolled or accepted for enrollment in an accredited educational institution on a full-time basis (full-time as defined by the institution attended). Scholarships will be awarded based on the individual's academic achievement, and are limited to a total of four (4) years duration (meaning either 8 semesters or 12 quarters of study. Throughout this section, the term "semester" shall also refer to "quarter," whichever structure as used by the applicable institution.).

If the Employee or a Dependent satisfied the eligibility requirements at the time of the Dependent's application for a scholarship and then subsequently retires or dies, the Dependent will be permitted to continue receiving the scholarship for the duration described above.

For purposes of this Scholarship Program:

- an Employee must be either a Group A Employee or a Group B Employee, and
- a Dependent Child shall be defined as an unmarried child who meets all of the following requirements:
    - is under age 26 at the time of initial enrollment in an accredited institution; OR is age 21 or older and has a permanent physical or mental condition that began prior to age 21 and that prevents the child from engaging in any self-sustaining employment;
    - has the same principal place of abode as you for the full year;
    - is a member of your household; and
    - is dependent upon you for over half of his or her support.

Unless the Dependent Child has a permanent physical or mental condition as defined above, a scholarship will terminate after the end of a semester following attainment of age 26.

Employees and Dependents covered under a STA-ILA Benefits Fund Participation Agreement are not eligible for scholarships under this program.

Standards for Judging Eligibility

Scholarships will be awarded based on an independent, objective assessment of each individual's academic achievement and extracurricular activities. All of the other rules governing Eligibility remain the same.

Types and Amounts of Scholarships

Scholarships are monetary awards granted by the Trustees to be used by Employees and their eligible Dependents for studies leading to associate or bachelor degrees at the college level, or business and trade schools above the high school level. The number and dollar amounts of the scholarships to be awarded are set by the Trustees at their discretion and may be changed from time to time. The Trustees are pleased to announce that effective in 2012, up to ten (10) new awards shall be provided annually with each award lasting up to four (4) years duration, in the amount of $2,000 per semester ($4,000 per academic year). This represents an increase in the annual number of possible new awards, as the limit was previously up to seven (7) new awards. A scholarship recipient's award shall be increased to $2,500 per semester ($5,000 per academic year) for the academic year immediately following a full academic year in which the recipient achieved a grade point average (GPA) of 3.0 or better in each semester.

Continuation of a Scholarship

Once a scholarship is awarded, the individual award recipient must, in addition to continuously satisfying the initial eligibility requirements described herein, maintain a cumulative grade point average (GPA) of 2.0 in order for the scholarship award to continue for the following school semester or year.

In other words, for a scholarship award to continue for each school semester, or year, the individual award recipient must continue to satisfy all of the following five (5) requirements:

- the individual must be an Employee or a Dependent as defined above, covered under the Collective Bargaining Agreement (and not under a STA-ILA Benefits Fund Participation Agreement);

- the Employee must have earned a total of ten (10) years of Vesting Service under the STA-ILA Pension Plan;

- the Employee must have earned a Year of Vesting Service in at least two (2) of the last three (3) Contract Years (October 1 to September 30);

- the individual award recipient must be enrolled in an accredited educational institution on a full-time basis (full-time as defined by the institution attended); and

- the individual award recipient must maintain a cumulative grade point average (GPA) of 2.0 or better.

If scholarship eligibility is lost for any reason, including either failure to maintain the two-year vesting requirement or the minimum GPA, the scholarship will not be continued for any subsequent semester, or year. Notwithstanding the foregoing, if loss of eligibility is due to failure to maintain full-time status in one semester in order for the student to be able to care for an ailing family member within the household, or due to the student's own illness, but the student then regains full-time status in the succeeding semester, the scholarship award will then be restored retroactive to that semester following successful completion of that semester with a minimum GPA of 2.0, and the award will continue for the duration of eligibility. In order to take advantage of this exception, the student must notify the Fund Office in writing of the illness within a reasonable period of time following loss of full-time status, and the notice must be accompanied by written verification of the illness by the attending physician or other qualified medical professional. Further, a scholarship recipient shall be entitled to only one opportunity to regain eligibility as provided for in this paragraph.

Each individual award recipient must furnish his or her official transcript (or other documentation as determined by the Fund Office) at the conclusion of every school semester or year, in order to verify full-time enrollment status and the GPA earned.

All capitalized terms herein that are not defined in the STA-ILA Benefit Plan Summary Plan Description are defined in the STA-ILA Pension Plan Summary Plan Description.

Application for Scholarships

All eligible Employees and their Dependents will be notified when the Trustees make scholarships available. An application for a scholarship must be made within the time limits set by the Trustees on the appropriate forms furnished by the Fund Office for that purpose. A Scholarship Application Form may be printed from the Plan's website at www.stailafunds.com.

General Exclusions

In addition to the specific exclusions listed in the various sections, the Plan does not provide benefits for expenses Incurred for or in connection with:

- occupational Injuries or Illness for which you are eligible to receive benefits from any worker's compensation or similar law;
- Injury or Illness caused by a third party and for which that third party is obligated to pay;
- medical services or supplies provided or paid by any federal, state, or local governmental agency or program, except as may be required by law;
- conditions caused by or arising out of an act of war or aggression, whether declared or not, or conflict involving the armed forces;
- conditions that are not treated by a Physician or licensed Health Care Provider;
- services or supplies that are not Medically Necessary for the treatment of an Injury or Illness;
- services that would not have been provided if coverage did not exist or for which you or your Dependents are not required to pay;
- commission, as a perpetrator, of a felony, misdemeanor, or other criminal activity;
- participation in a riot;
- travel and lodging, whether or not recommended by a Physician;
- failure to appear for a scheduled appointment or to provide claim forms or documents;
- Injuries or Illness that result from or occur because of your employment for wage or profit in an occupation that is not covered under this Plan;
- charges for services or supplies that are not recommended and approved by a Physician; or
- any other services or supplies that are not shown as being covered under this Plan.

Coordination of Benefits

The benefits payable to you under this Plan are "coordinated" with any benefits payable to you and/or your Dependents for the same expenses from group health plans.

Coordination of benefits or "COB" means that benefits payable from this Plan and from other insurance plans can equal but not exceed 100% of allowable expenses. This permits the actual expenses to be paid in full, up to certain allowable amounts, without duplicating the benefits. Coordination also establishes the priority of payment among group health plans.

"Allowable expenses" are any charges for benefits and services covered in full or in part under this Plan and any other plan under which the person making the claim is covered.

The following rules, in this order, determine whether a plan is considered primary or secondary:

- the plan that does not contain a COB provision is the primary plan and this Plan will be the secondary plan.

- the plan covering someone other than as a dependent (e.g., as an employee or retiree) is the primary plan; and the plan covering that person as a dependent is the secondary plan.

- the plan of the parent whose birthday (month and day only) falls earlier in the calendar year is the primary plan; or if both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

- special rules for coverage of Dependent Children in cases of legal separation or divorce or not living together, whether or not they have been married, apply as follows:

    - if there is a court decree establishing financial responsibility for the child, the plan that covers the child as a dependent of the parent named in the decree is primary, and the plan of the other parent will be secondary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

    - if a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Section (2) above will determine the order of benefits;

    - if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Section (2) above will determine the order of benefits;

    - if the parent with custody has not remarried, the benefit plan covering the child of the custodial parent is primary, and the plan covering the child of the non-custodial parent is secondary.

- if the parent with custody has remarried, the benefit plan covering the child of the custodial parent is primary, the plan covering the child of the custodial parent's spouse (the child's stepparent) is secondary, and the plan covering the child of the non-custodial parent pays third.

- the plan covering a person as a laid-off employee or retiree, or a dependent of such person, pays benefits after any other plan covering the person as an active employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the provisions under Section (2) above can determine the order of benefits.

- if a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the plan covering the person as an employee or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the provisions under Section (2) above can determine the order of benefits.

- the plan that has covered the employee or retiree for a longer period is the primary plan, and the plan that has covered the employee or retiree for a shorter period of time is the secondary plan.

- if a priority still is not established, the allowable expenses will be shared equally between the plans. The maximum amount payable under this Plan is the amount that would have been payable if this Plan was the primary plan.

If two plans are both secondary, the rules shown above are repeated until one plan is shown to be primary. Benefits are paid under a secondary plan only to the extent that they are not payable under any other plan.

If the primary plan is a Health Maintenance Organization (HMO), and your Dependent fails to use the designated physician, institution, or facility, this Plan will exclude from payment services that would have been provided by the HMO.

If you are covered by both this Plan and Medicaid, this Plan is the primary plan and Medicaid is the secondary plan.

If your Dependent is covered by both this Plan and TRICARE, this Plan is the primary plan and TRICARE is the secondary plan. If you are called to active duty for more than 30 days, TRICARE is primary and this plan is secondary.

If you are covered by both this Plan and any other coverage (not already mentioned above) that is provided by another state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Contact the Fund Office if you would like to know more about coordination of benefits.

Subrogation/Indemnification

This Plan has subrogation rules which apply when you are Injured or become ill and someone else is potentially responsible for your Illness or Injury. Under these rules, the Plan will advance the payment of benefits to cover your qualified claims, but if you recover money from a responsible third party (for example, by way of a lawsuit, a workers' compensation award, or a settlement), you are required to repay the Plan for the benefits it advanced, up to the amount of your recovery from the third party. Repayment is required even if your only monetary recovery is through your own insurance company.

The subrogation rules are in place to assist you, by paying your qualified claims while you proceed against the responsible third party. They also prevent a situation where you are compensated twice for the same Injury or Illness; once by the Plan when it pays your medical bills and a second time by the third party when it pays your damages for your loss. The bottom line is that the rules help to insure that assets are available for all of the Plan's Participants and beneficiaries.

If you are Injured or become ill and a third party (including an insurance company or a workers' compensation carrier) is potentially liable to you for the Illness or Injury, the Plan will advance payment of benefits on your behalf, but only under the following conditions:

- you must sign and return the Plan's Subrogation Agreement. Benefits will not be paid out on your behalf unless the Fund Office receives a copy of the Agreement signed by you (and your attorney if one has been retained).

- if you recover money from a third party, you must repay the Plan for the benefits it paid on your behalf, up to the amount of your recovery. (Example: the Plan pays out $15,000 in claims on your behalf. Later, you recover $25,000 from a third party. You must reimburse the Plan for the $15,000 of benefits paid on your behalf).

- this repayment obligation applies to any recovery from a third party, regardless of whether the payment is characterized as compensation for pain and suffering or something else.

- your obligation to repay the Plan has priority over other obligations you may have, including any obligation to pay attorneys' fees out of the recovery. You may not reduce the amount you owe the Plan to account for the payment of attorney's fees or other obligations.

- if you recover money, but fail or refuse to repay the Plan, future health and welfare benefits, including Death Benefits will not be paid on your Dependents' behalf until such time as the Plan offsets the full amount due to be reimbursed under these rules plus 10% interest per annum.

- the Plan may also choose to bring legal action against you to collect monies due under these subrogation rules. If the Plan prevails, you must also pay interest at the rate of 10% per annum and the Plan's reasonable attorneys' fees.

If you have any questions regarding these subrogation rules, please feel free to contact the Fund Office.

Claim Procedures

To ensure the prompt payment of a claim for benefits, please keep a detailed record of all covered expenses Incurred by you and your Dependent(s). You should keep in mind that it might be someone else's responsibility to file a claim for benefits, for example, in the event of Disability or death. Therefore, it is suggested that someone in addition to you read this Summary Plan Description ("SPD") and become familiar with the Plan's benefits and claims procedures.

In general, claims for benefits are paid directly to you. This is because most claims for benefits are for charges that have already been paid by you or your Dependents over age 18. However, in some instances claims may be paid to the person or entity that provided the service or supply.

What is a Claim

A "claim" is a written request on a pre-approved form from you or your authorized representative for payment of your Plan benefits made in accordance with the Plan's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims, nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a claim. However, if you file a claim for a specific benefit and your claim is denied because you are not eligible for the benefit under the Plan, the coverage determination is considered a claim.

Interactions between you and a participating provider do not constitute a claim in a case where the provider exercises no discretion on behalf of the Plan. However, if the provider declines to render service unless you pay the entire cost, you should submit a claim for the service, as described under the "Determination of a Benefit Claim" section, below.

In addition to an application for benefits under the following: Hearing Aid Reimbursement Benefits, Specialist Reimbursement Account Benefits, and Weekly Accident and Sickness Benefits, a claim also includes a rescission of coverage of any of the above benefits whether or not there is an adverse effect on any particular benefit.

An adverse benefit determination does not include rescissions of coverage with respect to any of the following benefits: Accidental Death and Dismemberment, Life Insurance, Death Benefits and Scholarship Program Benefits.

Notice of a Claim Decision

With respect to claims for Hearing Aid Reimbursement Benefits, Specialist Reimbursement Account Benefits, and Weekly Accident and Sickness Benefits, where there is an adverse determination, the written notice of a denial of a claim will include the following information, in addition to that listed in the SPD:

- a statement of your right, upon request and free of charge, to reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;

- either the specific internal rules, guidelines, protocol, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

With respect to Weekly Accident and Sickness Benefits, the written notice of a denial of a claim will include, in addition to the contents listed in the SPD:

- a description of the Plan's discussion of the initial claim decision, including the basis for disagreeing with:

  - any disability determination by the Social Security Administration (SSA) with regards to you;

  - the views presented to the Plan, of a treating health care professional or vocational expert evaluating you, to the extent the Plan does not follow such views as presented by you; or

  - the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination.

Review Process

Before issuing an adverse benefit determination on appeal with respect to Hearing Aid Reimbursement Benefits, Specialist Reimbursement Account Benefits, and Weekly Accident and Sickness Benefits:

- you will be provided with a reasonable opportunity to respond, by presenting written evidence and testimony, to any new or additional information.

- the Plan will automatically provide you, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim.

- the Plan will automatically provide you with any new or additional evidence or rationale as soon as possible once it becomes available to the Plan sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided.

- this new or additional evidence or rationale will be provided to you so that you will have a reasonable opportunity to respond regarding the new or additional evidence or rationale, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided.

- if the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond.

- after you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.

Notice of a Decision on Review of Appeal

With respect to Weekly Accident and Sickness Benefits, the notice of a denial of a claim on review will include, in addition to the contents listed in the SPD:

- a description of the Plan's decision, including the basis for disagreeing with:

  - any disability determination by the Social Security Administration (SSA);

  - the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or

  - the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination; and

Decision of Trustees

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals, and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination, or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

To the extent required by applicable law, any notices will be provided in a culturally and linguistically appropriate manner.

Filing a Claim

Claims must be submitted in writing on pre-approved forms. A completed claim form usually contains the necessary proof of claim, but sometimes additional information or records may be required. The claim form must be completed in full for each family member, including all information and statements from the providers of service. Be sure that you properly sign each form.

Your claim for benefits will be considered for payment upon the receipt of a completed claim form by the appropriate party responsible for determining the initial determination of the claim.

Contact the Fund Office at (410) 633-9311 to obtain claim forms for the following benefits:

- Weekly Accident and Sickness Benefits;
- Accidental Death and Dismemberment Insurance Benefits;
- Life Insurance Benefits; and/or
- Death Benefits.

File your completed claim form with the Fund Office at:

STA-ILA Benefits Trust Fund
Holabird Business Park
6610 Tributary Street
Baltimore, MD 21224-6514
or by facsimile at (410) 633-9347

No claim forms are required for Hearing Aid Reimbursement Benefits or Specialist Reimbursement Account Benefits.

Filing Deadlines

Certain filing deadlines must be met in order to ensure that your claims are paid.

All Benefits

In general, claims shall be considered for payment upon receipt within the deadlines specified above, or for claims that do not have a deadline specified below, within 90 calendar days from the date the service or supply is provided. *However, a claim shall not be considered for payment after one year from the date the service or supply is provided*.

Weekly Accident and Sickness Benefit

The Fund Office must be notified in writing of an Illness or Injury for which benefits are payable within 90 calendar days after the day the Illness or Injury occurs.

Life Insurance and Accidental Death and Dismemberment Insurance Benefits

In case of claims for Life Insurance Benefits or Accidental Death and Dismemberment Insurance Benefits, proof of loss must be furnished to the Fund Office within one (1) year after the date of loss.

The Trustees for good cause may waive a filing deadline on a non-precedent basis.

Right to an Authorized Representative

If you wish, you can appoint an authorized representative to act on your behalf for the purposes of filing a claim and seeking a review of a denied claim. You also can simply choose to represent yourself. In order to use an authorized representative (this person may be an attorney, but need not be), however, you must notify the Fund Office in advance, by completing and submitting a designated form. Contact the Fund Office to obtain a form to appoint an authorized representative.

Determination of a Benefit Claim

The determinations of benefit claims will vary depending on the type of claim. The period of time for the Plan to make a benefit determination begins at the time the claim is filed in accordance with the Plan's procedures, without regard to whether all the necessary information accompanies the filing. Please read each section carefully to determine which procedure is applicable to your request for benefits.

Hearing Aid Reimbursement Benefit and Specialist Reimbursement Account Benefit

No claim forms are required for Hearing Aid Reimbursement Benefits or Specialist Reimbursement Account Benefits. Contact the Fund Office to submit requests for reimbursement of Hearing Aid Reimbursement Benefits or Specialist Reimbursement Account Benefits.

File your request for reimbursement with the Fund Office at:

STA-ILA Benefits Plan
Holabird Business Park
6610 Tributary Street
Baltimore, MD 21224-6514
or by facsimile at (410) 633-9347

Ordinarily, you will be notified of decisions within *30 calendar days* from the receipt of the request. The Plan may extend this period one time for up to *15 calendar days* if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified, before the end of the *initial 30-day period*, of the circumstances requiring the extension and the date by which a benefit determination is expected to be rendered.

If an extension is required because the Plan needs additional information from you, the extension notice will specify the information needed. You will have *45-calendar days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your request will be denied. During the *45-day* period in which you are allowed to supply additional information, the normal deadline for making a decision on the request will be suspended. The deadline is suspended from the date of the extension notice until either *45-calendar days* or until the *date you respond to the request*, whichever is earlier. The Plan then has *15 calendar days* to make a decision on the request and notify you of the determination.

Weekly Accident and Sickness Benefit

If your claim for Weekly Accident and Sickness Benefits has been denied, in whole or in part, you will be notified in writing within 45 calendar days after your claim has been received. If the Plan needs more time to review your claim for reasons beyond its control, it may take an additional 30 calendar days. Should additional time be required, you will be sent a notice of this extension before the initial 45-day period expires specifically explaining the circumstances requiring the extension, the date by which the a benefit determination is expected to be rendered, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information necessary to resolve those issues.

A second 30-day extension of time is also available to the Plan should the Plan determine that such an extension is necessary because a decision cannot be rendered within the extension period due to reasons beyond the Plan's control. If a second extension is necessary, the notice of the second extension will be sent to you before the first 30-day extension period expires, and will include the same notification requirements listed in the paragraph above. In no event will the Plan's extensions exceed 105 calendar days from the date your original claim is made.

If an extension is required because the Plan needs additional information from you, the extension notice will specify the information needed. You will have *45 calendar 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 *45-day* period in which you are allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either *45-calendar days* or until the *date you respond to the request*, whichever is earlier.

Accidental Death and Dismemberment, Life Insurance, Death, and Scholarship Benefit

If your claim for Accidental Death and Dismemberment Insurance, Life Insurance, Death, or Scholarship Program Benefits is denied, in whole or part, you will receive a written notice of the denial within 90 calendar days after your claim has been received. Should special circumstances require additional time to decide your claim, you will be provided with a written notice of the extension within 90 calendar days after receipt of your claim explaining the special circumstances and the date by which a benefit determination is expected to be rendered. This extended due date cannot exceed 180 calendar days from the date on which your claim originally was filed (in other words, the extension itself cannot exceed 90 calendar days).

If an extension is required because the Plan needs additional information from you, the extension notice will specify the information needed. You will have *45 calendar 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 *45-day* period in which you are allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either *45-calendar days* or until the *date you respond to the request*, whichever is earlier.

Notice of a Claim Decision

If your claim is denied, in whole or in part, you will be provided with written notice of a denial of a claim. This notice will state:

- the specific reason(s) 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 appeal procedures and applicable time limits.
- a statement of your right to bring a civil action under the Employee Retirement Income Security Act ("ERISA") Section 502(a) following an adverse benefit determination on review.

With respect to claims other than for Accidental Death and Dismemberment Insurance Benefits, Life Insurance, Death, and Scholarship Program Benefits:

- if an internal rule, guideline, or protocol was relied upon in deciding your claim, you will receive a statement that the rule 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 a statement that the explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim is available upon request at no charge.

Request for a Review of Denied Claim - Appeal Procedures

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you or your authorized representative may ask for the claim to be reviewed. All appeals must be made in writing to the Board of Trustees and submitted to the Co-Administrators.

Hearing Aid Reimbursement, Specialist Reimbursement Account, and Weekly Accident and Sickness Benefit Claims

You have 180 calendar days from the day you received notice of the initial decision to appeal the claim.

Accidental Death and Dismemberment, Life Insurance, Death, and Scholarship Benefit Claims

You have 60 calendar days from the day you received notice of the initial decision to appeal the claim.

Review Process

You have the right, upon request and free of charge, to receive reasonable access to and copies of all documents "relevant" to your claim. A document, record, or other information is relevant if:

- it was relied upon in making the decision;
- it was submitted, considered, or generated in the course of making the benefit determination (regardless of whether it was relied upon);
- it demonstrates compliance with the administrative processes for ensuring consistent decision making; or
- with respect to claims other than for Life Insurance or Accidental Death and Dismemberment Insurance Benefits claim, it constitutes a statement of Plan policy regarding the denied treatment or service.

The review will take into account all comments, documents, records and other information you submit relating to the claim (regardless of whether this information was submitted or considered in the initial benefit determination).

With respect to claims other than Accidental Death and Dismemberment Insurance Benefits, Life Insurance, or Death Benefit claims:

- upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the organization responsible for the initial determination of your claim, without regard to whether their advice was relied upon in deciding your claim.
- a different person will review your claim than the one who originally denied the claim. The reviewer will not 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 Notification of Decision on Appeal

Ordinarily, decisions on 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 calendar 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 5 calendar days after the decision has been reached.

Notice of a Decision on Review of 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.

With respect to claims other than Accidental Death and Dismemberment Insurance Benefits, Life Insurance, or Death Benefit claims:

- a statement that if an internal rule, guideline, or protocol was relied upon by the Plan, it is available upon request at no charge.
- if the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, is available upon request at no charge.

Decision of Trustees

The denial of an application or claim to which the right of review has been waived or the decision of the Trustees, or its designees with respect to a petition for review, shall be final and binding upon all parties, including the applicant, claimant, or petitioner, and any person claiming under the application, claimant, or petitioner, subject only to judicial review. The provisions of this Section shall apply to and include any and every claim to benefits from the Plan, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the

claim, regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "Participant" or "Beneficiary" of the Plan within the meaning of those terms as defined in ERISA.

Limitation on When a Lawsuit May be Started

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 described above 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 ERISA without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than one (1) year after the end of the year in which medical services were provided, or, if the claim is for Weekly Accident and Sickness Benefits, more than one (1) year after the start of the disability.

General Plan Provisions

This Section gives you information that you may find useful whenever you have questions about your Plan. It contains names and addresses of people and organizations you may need to contact.

Name of Plan

STA-ILA Benefits Plan for Active Employees

Plan Identification Numbers

EIN: 52-0575721
Plan Number: 501

Plan Year

October 1 through September 30

Type of Plan

An employee welfare benefit plan providing Weekly Accident and Sickness Benefits, Life Insurance, Death Benefits, Accidental Death and Dismemberment Insurance, Dental Benefits, Vision Benefits, a Specialist Reimbursement Account, and Hearing Aid Reimbursement Benefits.

Plan Sponsor

The Board of Trustees of the STA-ILA Benefits Trust Fund. All communications to the Plan Sponsor should be sent to:

Board of Trustees
STA-ILA Benefits Trust Fund
Holabird Business Park
6610 Tributary Street
Baltimore, MD 21224-6514

Trustees

A complete list of Employers and employee organizations sponsoring the Plan may be obtained upon written request to the Plan Co-Administrator, and is available for examination. In addition, you may receive from the Plan Co-Administrator, upon written request, information as to whether a particular Employer or employee organization is a plan sponsor, and if so, the sponsor's address.

Plan Administrator/Fund Office

Richard P. Krueger III, Co-Administrator
Richard P. Wohlfort, Jr., Co-Administrator
STA-ILA Benefits Trust Fund
Holabird Business Park
6610 Tributary Street
Baltimore, Maryland 21224-6514
Telephone: (410) 633-9311

Agent for Service of Legal Process

The Co-Administrators of the Plan, Richard P. Krueger III and Richard P. Wohlfort, Jr., have been designated as the agent for the service of legal process and may be served at the Fund Office. Service of legal process may be upon either of the Co-Administrators or upon a Plan Trustee.

Plan Administration, Sources of Contributions, and Funding

The Board of Trustees of the STA-ILA Benefits Trust Fund administers the day-to-day operations of the Plan.

The Board of Trustees is made up of members designated by the Steamship Trade Association of Baltimore, Inc., whose Employer-members contribute to the Fund, and members designated by the Union. The Employer and Union Board members, as entities, have an equal vote on all matters regardless of the number of members in attendance at a particular Trustees' meeting. The Board of Trustees retains the exclusive discretion and authority to alter the terms, conditions, or benefits of the Plan, and make all decisions regarding interpretations and the application of all Plan provisions.

Contributions to the Plan are made by Employers who are obligated to contribute to the Fund in accordance with a Collective Bargaining Agreement or a Benefits Fund Participation Agreement. The contributions are based on the number of hours paid to Employees of contributing organizations.

All benefits under the Plan are self-funded except the Accidental Death and Dismemberment Insurance Benefits and the Life Insurance, which are insured by The Hartford Life and Accident Insurance Company. Plan assets are held and accumulated in the STA-ILA Benefits Trust Fund. Plan benefits are payable from the Trust Fund.

Collective Bargaining Agreements

The Plan is maintained pursuant to one or more Collective Bargaining Agreements. Copies of the Agreements may be obtained by Participants and Dependents upon written request to the Plan Co-Administrator and are available within 30 calendar days after written request is received and directed to the Plan Co-Administrator.

Summary Annual Report and Plan Changes

You will receive a free summary of the Plan's annual report once each year. You will be notified if any modifications are made to the Plan.

Discretionary Authority of the Board of Trustees and its Designees

In carrying out their responsibilities under the Plan, the Board of Trustees has full and exclusive discretionary authority to construe and interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination by the Board of Trustees is final and binding upon any person claiming benefits under the Plan.

Amendment or Termination of the Plan

Neither this Plan nor any of its benefits are guaranteed. Although the Plan is intended to be permanent, the Board of Trustees reserves the right at any time to amend, change, or terminate the Plan, in whole or in part, as it finds necessary. The nature and amount of Plan benefits always are subject to the actual terms of the Plan as it exists at the time the claim occurs.

No Liability for the Practice of Medicine

The Fund, the Plan, the Board of Trustees, and their designees are not engaged in the practice of medicine and have no control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care providers. You should select a provider or course of treatment based on all appropriate facts, only one of which should be coverage by the Plan. Neither the Plan, the Plan Co-Administrator, nor any of its designees will have any liability whatsoever for any loss of injury caused by you or your health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Rights of Recovery

If you or your Dependent files a false claim or receives payment from the Plan as a result of a mistake on your part or the Plan's part, you must make immediate repayment to the Plan upon request. Failure to make full reimbursement within 30 days of the date of the Plan's request may result in the following:

- interest added to the amount due at the court established legal rate of interest in Maryland;
- future benefits offset by claims filed by you and your Dependents until such time the Plan would have paid out in benefit payments completely offsets the amount that is due to be reimbursed to the Plan;
- a lawsuit filed against you to recover the overpayment (including interest), court costs, and attorneys' fees;

- if you or your eligible Dependent files a false claim or receives payment from the Plan through misrepresentation, in addition to the penalties listed previously, you and your Dependents may be denied future coverage under this Plan; and

- the Fund Office may also notify the proper legal authorities if it appears that you or your Dependent has submitted falsified information to the Plan.

Privacy, Confidentiality, Release of Records or Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that the Plan protect the confidentiality of your private health information. The Plan maintains a Notice of Privacy Practices that provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, please contact the Fund Office. This summary is not intended and cannot be construed as the Plan's Notice of Privacy Practices. In the event of any inconsistency between this summary and the Notice of Privacy Practices, the terms of the Notice control.

The Plan and the Board of Trustees will not use or further disclose information that is protected by HIPAA (known as "protected health information" or "PHI") except as necessary for treatment, payment, healthcare operations, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities called, "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that organization.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

If you have questions about the privacy of your health information, or if you wish to file a privacy violation complaint, please contact the Plan's Privacy Official at the Fund Office address located in the front of this Summary Plan Description ("SPD").

Named Fiduciary Under ERISA

The named fiduciary under the Plan is the Board of Trustees.

No Assignment of Benefits

You may not assign your benefits under the Plan, except that you may direct that benefits payable to you be paid to an institution or a provider of medical care. However, the Plan is not legally obligated to accept such a direction from you, and no payment by the Plan to a provider can be considered to be a recognition by the Plan that it has a legal duty to pay the provider, except to the extent that it chooses to do so. Notwithstanding the foregoing, the Board of Trustees shall provide benefits in accordance with the applicable requirements of a Qualified Medical Child Support Order.

Governing Law

This Plan is created and accepted in the State of Maryland and all questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Maryland except to the extent preempted by federal law.

Savings Clause

Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect other provisions of this Plan or the application of any provisions to any other person or instance unless such illegality shall make impossible the functioning of this Plan.

Titles

The title of any Article, Section, or provision of this Plan is for convenience and reference only and is not to be considered in interpreting the terms and conditions of this Plan.

Construction of Words

Any words used in this Plan in the masculine gender shall be construed as though they also are used in the feminine gender in all situations where they would so apply. Any words used in this Plan in the singular form shall be construed as though they also are used in the plural form in all situations where they would so apply, and vice-versa.

Your ERISA Rights

As a Participant in the STA-ILA Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan Participants shall be entitled to:

- receive information about your Plan and benefits.

- examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan 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 Co-Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Co-Administrator may make a reasonable charge for the copies.

- receive a summary of the Plan's annual financial report. The Plan Co-Administrator is required by law to furnish each Participant with a copy of this summary annual report.

- continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan, and do not receive

them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting your administrative remedies by appealing the matter to the Board of Trustees. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Benefit Schedule

Benefit	Group A Employees	Group B Employees
Weekly Accident and Sickness Benefit (*Employees Only*)		
For Top Tier wage category per the Master Agreement as of the October 1st preceding onset of Illness or Injury	$540 per week	$195 per week
For other than Top Tier wage category per the Master Agreement as of the October 1st preceding onset of Illness or Injury	$425 per week	$125 per week
Life Insurance Benefit (*Employees Only*)	$50,000	$15,000
Death Benefit		
Dependent Spouse	$15,000	$10,000
Dependent Child (as defined in page 3)	$10,000	$10,000
Accidental Death and Dismemberment Insurance Benefit (*Employees Only*)		
Accidental Death	$21,000	$7,000
Loss of any combination of hands, feet or eyesight	$21,000	$7,000
Loss of one hand or one foot or sight of one eye	$10,500	$3,500

Benefit	Group A Employees	Group B Employees
Dental Benefit – In-Network (No Out-of-Network Benefits)	**MILA's primary coverage amounts are subtracted from the Plan's obligation.**	
Deductible	$25 individual deductible per calendar year. $50 family deductible per calendar year. Waived for preventive dental treatment.	
Preventive Dental Treatment	Plan pays 100% for one visit every six months	
Basic and Major Dental Treatment	Plan pays 100% up to $2,500 per person per calendar year for in-network claims. However, the per calendar year limit for in-network claims for implants, dentures, bridgework and crowns is $5,000 per person. The Fund Office maintains a listing of ADA Dental Codes for services that are subject to the $5,000 limit; you may request a copy of this listing from the Fund Office.	
Orthodontic Dental Treatment	Plan pays up to $3,200 per lifetime for Dependent Children through the end of the Calendar Year in which the eligible Dependent Child reaches the age of 21, regardless of any treatment in progress.	
Vision Care Benefit – In-Network (No Out-of-Network Benefits)	**MILA's primary coverage amounts are subtracted from the Plan's obligation**	
Examination (one exam every 12 months)	Plan pays 100%.	
Two ophthalmologic exams within two years of a diagnosis of cataracts	Plan pays 100%.	
Frames (one pair of frames every 12 months)	Plan pays 100% up to $200.	
Standard plastic lenses (one set of lenses every 12 months)	Plan pays 100% up to $300 above the MILA basic benefit. This covers single vision, bifocal, trifocal, lenticular, or progressive lenses (standard/premium).	
Contact lenses in lieu of frames/lenses (one set of contact lenses every 12 months, including fitting fees)	Plan pays 100% up to $200.	
Specialist Reimbursement Account	The Plan will reimburse up to $15.00 of this copayment amount per specialist visit.	

Benefit	Group A Employees	Group B Employees
Hearing Aid Reimbursement Benefit (MILA's primary coverage amounts are subtracted from the Plan's obligation)	80% of the first $2,000 of Covered Expense per hearing aid, per ear, for each 3-year benefit period.	
Scholarship Fund (eligibility as defined on page 48)	Up to ten (10) new awards provided each year, up to 4 years duration each, in the amount of $2,000 per semester ($4,000 per academic year); increased to $2,500 per semester ($5,000 per academic year) in year immediately following a full year GPA of at least 3.0. The number and dollar amounts of the scholarships to be awarded are set by the Trustees at their discretion and may be changed from time to time.	

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