

**STA-ILA BENEFITS TRUST FUND
FOR ACTIVE EMPLOYEES**

**SUMMARY OF MATERIAL MODIFICATIONS
(Modification #1 to January 1, 2015 SPD Restatement)**

The Trustees are pleased to announce a change in the rules governing the Death benefit for a Dependent child under the **STA-ILA Benefits Trust Fund** (the "Plan"). This notice explains the change in the information presented in your Summary Plan Description (sometimes called an "SPD"). You should:

- Read this notice carefully, and if you have any questions, contact the Plan Administrator at (410) 633-9311.
 - Keep this notice with your Summary Plan Description.
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DEATH OF DEPENDENT CHILD

Effective January 1, 2017, 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 of \$10,000. Previously, this Death benefit was applicable for a Dependent child under the age of 21. The Death benefit for your Dependent child under the age of 26 is self-funded by the Plan. Your Dependent child's name must be on file at the Administrative Office. In order to receive the Death benefit, you must contact the Administrative Office within 60 days of the death of your Dependent child.

Please place this in your SPD Booklet for handy reference and safekeeping.

The members of the Board of Trustees are on the following two pages.

Sincerely,

**BOARD OF TRUSTEES
March 2017**

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**STA-ILA BENEFITS TRUST FUND
FOR ACTIVE EMPLOYEES**

**SUMMARY OF MATERIAL MODIFICATIONS
(Modification #2 to January 1, 2015 SPD Restatement)**

The Trustees are pleased to announce clarifications and changes to a number of rules governing various provisions under the **STA-ILA Benefits Trust Fund** (the "Plan"). This notice explains the clarifications and changes in the information presented in your Summary Plan Description (sometimes called an "SPD"). You should:

- Read this notice carefully, and if you have any questions, contact the Plan Administrator at (410) 633-9311.
 - Keep this notice with your Summary Plan Description.
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I. SUBSTANCE ABUSE

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 Administrative 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:

1. 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.
2. Assistance in coordinating A&S benefits for employees entering into treatment or who are in treatment.
3. Assistance with completing required documents for substance abuse treatment.
4. Assistance in obtaining medical documents for reinstatement when returning to the workforce.
5. Research and comparison of rehabilitation facilities to best fit participant treatment needs.
6. Assistance to participants with education regarding employee requirements when under one-year suspension and report to the Drug and Alcohol Committee.
7. 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 CBA's grievance procedures. Participants should direct those inquiries to the STA-ILA Drug and Alcohol Abuse Committee.

II. HEARING AID EXPENSE 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

Effective July 1, 2016, all hearing aid benefit claims must first be submitted to MILA's designated hearing aid benefit manager. This 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 this Plan.

For example, if this Plan would have paid \$1,550 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 \$50. Conversely, if MILA's designated hearing aid benefit manager would have provided a benefit of \$1,000 and this Plan provides \$800 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 booklet. In addition, benefits are not payable for:

- Batteries;
- Repair of hearing aids; and
- Expenses that are covered under any other Section of the Summary Plan Description.

III. COBRA (CONTINUATION OF COVERAGE)

Because the Plan's dental, vision, hearing aid 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.

IV. ENROLLMENT

As stated in the SPD, an enrollment card for benefits coverage must be filed with the Administrative Office in order to be eligible for Employee coverage, and where applicable, coverage for your Spouse or Dependents. The general rule is that you must appear in person at the Administrative Office to fill out the card and provide required information. An exception to this rule is as follows: in the event you first satisfy the hours of work requirement in a Plan Year for eligibility in the succeeding Calendar Year but die before appearing at the Administrative Office to complete an enrollment card, your Spouse will be permitted to fill out the card and provide required information.

V. LIFE, DEATH & ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Effective January 1, 2018, the Plan's life insurance and accidental death and dismemberment benefits covering you, and death benefits covering your Spouse will be provided by The Hartford Life and Accident Insurance Company (the Plan's death benefits covering your Dependent children will continue to be self-funded).

Additionally, for Plan A Employees the accidental death benefit covering you is increased to \$21,000; loss of any combination of hands, feet or eyesight benefit is increased to \$21,000; and loss of one hand or one foot or sight of one eye benefit is increased to \$10,500. For Plan B Employees, the accidental death benefit covering you is increased to \$7,000; loss of any combination of hands, feet or eyesight benefit is increased to \$7,000; and loss of one hand or one foot or sight of one eye benefit is increased to \$3,500. You must contact the Administrative Office at (410) 633-9311 to report a death or for the appropriate form to submit a claim for benefits.

Please place this in your SPD Booklet for handy reference and safekeeping.

The members of the Board of Trustees are on the following two pages.

Sincerely,

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December 2017**

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**STA-ILA BENEFITS TRUST FUND
FOR ACTIVE EMPLOYEES**

**SUMMARY OF MATERIAL MODIFICATIONS
(Modification #3 to January 1, 2015 SPD Restatement)**

The Trustees are pleased to announce clarifications and changes to a number of rules governing your dental, vision and scholarship benefits under the **STA-ILA Benefits Trust Fund** (the "Plan"). This notice explains the clarifications and changes in the information presented in your Summary Plan Description (sometimes called an "SPD"). You should:

- Read this notice carefully, and if you have any questions, contact the Plan Administrator at (410) 633-9311.
 - Keep this notice with your Summary Plan Description.
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I. DENTAL BENEFITS

The Plan offers supplemental dental coverage 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.

For in-network dental services, effective July 1, 2018, the Plan's benefits are as follows:

- Individual Deductible: \$25 per calendar year (no more than \$50 per calendar year per family), waived for preventive dental treatment
- Preventive Dental Treatment: 0% Coinsurance, Plan pays 100% for one visit every six months
- Basic and Major Dental Treatment: 0% Coinsurance, Plan pays 100% up to \$2,500 per person per calendar year. However, the per calendar limit for in-network claims for implants, dentures, bridgework and crowns is \$5,000 per person. The Administrative Office maintains a listing of ADA Dental Codes for services that are covered by the \$5,000 limit; you may request a copy of this listing from the Administrative Office.
- Orthodontic dental treatment: 0% coinsurance, Plan pays up to \$3,200 per lifetime for Dependent children up to the end of the Calendar Year in which the eligible Dependent child reaches the age of 21, regardless of any treatment in progress.

The following are the other in-network dental benefits provided by the Plan, up to the limits specified above:

- 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
- Additionally, the Plan will generally reimburse, up to the limits specified above, 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 above, 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 Administrative 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 Administrative 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 Administrative 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 Administrative 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;
- The implant benefit covers the use of implants that are FDA-approved and ADA-acceptable. Further, implant replacements will be covered by the Plan 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. In addition to the surgical implant procedure, this allowance will also cover subsequent maintenance visits as required, as well as cleanings and repair and/or replacement of screws or attachments.
- 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 in connection with birth defect or mainly for cosmetic reasons; exception: benefits will be provided for trauma, to whole sound natural teeth after the effective date of dental benefit coverage;
- 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.

II. VISION CARE BENEFITS

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.

For in-network vision services, effective July 1, 2018, the Plan's benefits are as follows:

- Examination (once per 12 months): \$0 Co-pay, Plan pays 100%. In addition, the Plan also covers two ophthalmologic exams within two years of a diagnosis of cataracts.
- Frames: \$0 Co-pay, Plan pays 100% up to \$200 for one pair of frames every 12 months.
- Standard plastic lenses: \$0 Co-pay, Plan pays 100%, up to \$300 above the MILA basic benefit for one set of lenses every 12 months. This covers single vision, bifocal, trifocal, lenticular, or progressive lenses (standard/premium). Covered lens options consist of the following: UV treatment, solid or fashion/gradient tint, blended segment, high index, scratch coating, polycarbonate (single vision or multi-focal for children under age 19), anti-reflective coating (standard/premium), polarized or photochromatic/transition.
- Contact lenses in lieu of frames/lenses: \$0 Co-pay, Plan pays 100% up to \$200 for one set of contact lenses every 12 months, including fitting fees.

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 above, 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 Administrative 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 Administrative 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 Administrative 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 Administrative 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 care benefits are subject to the Subrogation/Indemnification provisions described in the SPD.

Exclusions

Vision Care Expense 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.

III. SCHOLARSHIP

Eligibility

Employees and Dependents covered under a Collective Bargaining Agreement 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).

If the Employee of 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 or quarter following attainment of age 26.

Employees and Dependents covered under a STA-ILA Benefits Fund Participation Agreement and Dependent Parents 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 grade point average (GPA) of 2.0 or better in each semester, in order for the scholarship award to continue for the following school semester, quarter, or year.

In other words, for a scholarship award to continue for each school semester, quarter, 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 grade point average (GPA) of 2.0 or better in each semester.

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, quarter, or year. However, if loss of eligibility is due to failure to maintain the minimum GPA, and the individual subsequently achieves a 2.0 GPA or better during the immediately succeeding semester or quarter (whichever applicable), the scholarship award will then be restored retroactive to that semester or quarter following the sub-2.0 GPA, and the award will continue for the duration of eligibility. However, such individual shall be entitled to only one opportunity to regain eligibility as provided for in this paragraph.

The Trustees require that each individual award recipients furnish his or her official transcript (or other documentation as determined by the Administrative Office) at the conclusion of every school semester, quarter, 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 Administrative Office for that purpose.

Please place this in your SPD Booklet for handy reference and safekeeping.

The members of the Board of Trustees are on the following two pages.

Sincerely,

**BOARD OF TRUSTEES
March 2018**

Employer Trustees

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**SUMMARY OF MATERIAL MODIFICATIONS
(Modification #4 to January 1, 2015 SPD Restatement)**

The Trustees hereby announce clarifications and the following changes to a number of rules governing your benefits under the **STA-ILA Benefits Trust Fund** (the “Plan”). This notice explains the clarifications and states the changes made to the information contained in your current Summary Plan Description (referred to as an “SPD”).

You should:

- Read this notice carefully, and if you have any questions, contact the Plan Administrator at (410) 633-9311.
 - Keep this notice in a safe place along with a copy of your Summary Plan Description for handy reference.
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CLAIMS PROCEDURES

Effective April 1, 2018, the following additional rules will apply with respect to procedures that govern claims and appeals for disability benefits:

What is a Claim

In addition to an application for benefits under the following: hearing aid expense 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 and scholarship program benefits.

Notice of a Claim Decision

With respect to claims for hearing aid expense 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:
 - (i) Any disability determination by the Social Security Administration (SSA) with regards to you;
 - (ii) 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
 - (iii) 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 expense 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:
 - (i) Any disability determination by the Social Security Administration (SSA);
 - (ii) 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
 - (iii) 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.

The members of the Board of Trustees are on the following two pages.

Sincerely,

**BOARD OF TRUSTEES
April 2018**

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**STA-ILA BENEFITS TRUST FUND
FOR ACTIVE EMPLOYEES**

**SUMMARY OF MATERIAL MODIFICATIONS
(Modification #5 to January 1, 2015 SPD Restatement)**

The Trustees hereby announce the following changes to the Weekly Accident and Sickness Benefit under the **STA-ILA Benefits Trust Fund** (the "Plan"). This notice explains the changes made to the information contained in your current Summary Plan Description (referred to as an "SPD").

You should:

- Read this notice carefully, and if you have any questions, contact the Plan Administrator at (410) 633-9311.
 - Keep this notice in a safe place along with a copy of your Summary Plan Description for handy reference.
-

Weekly Accident and Sickness Benefit

Effective for illnesses or injuries which commence on or after January 1, 2019, if you qualify for the Weekly Accident and Sickness benefit, the 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. The previous maximum duration was 52 weeks. This change affects the following sections of the SPD:

If You Become Disabled (pages 9-10)

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 Administrative Office in writing within 90 calendar days after the day the illness or injury occurs.

Credit Hour Limitation (page 15)

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.

Duration of Benefits (page 29)

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.

The members of the Board of Trustees are on the following two pages.

Sincerely,

**BOARD OF TRUSTEES
October 2018**

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