AMENDMENT NO. 18-2

TO THE

RULES AND REGULATIONS

OF THE

MEBA MEDICAL AND BENEFITS PLAN

At their February 21, 2018 meeting, the Trustees of the MEBA Medical and Benefits Plan (the "Plan") approved the following changes to the Plan's Rules and Regulations to comply with Department of Labor regulations related to claims and appeals for disability benefits, effective April 1, 2018.

1. Article XVI, Section 7.B(5) shall be amended to read as follows:

Claim Denial

"

(5) In the case of an adverse determination involving disability benefits:

(a) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse determination, without regard to whether the advice was relied upon in making the determination; and

(iii) A disability determination regarding the claimant made by the Social Security Administration, if that determination was presented by the claimant to the Plan;

(b) If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(c) A copy of the specific internal rules, guidelines, protocols, 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; and

(d) A statement that the claimant is entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

2. Article XVI, Section 7.B shall be amended to add the following new paragraph (6) at the end thereof:

(6) Any notice provided pursuant to paragraph (5) will be provided in a culturally and linguistically appropriate manner with a statement prominently displayed in any applicable non-English language, as defined in guidance published by the Secretary of Labor pursuant to 29 C.F.R. § 2560.503-1(o), clearly indicating how to access the language services provided by the Plan. Additionally, an adverse determination shall include rescissions of disability coverage, regardless of whether the rescission had an adverse effect on any particular benefit, unless it is attributable to a failure to timely pay required premiums of contributions towards the cost of coverage.

3. Article XVI, Section 7.C. shall be amended to read as follows (***new language shown in bold italics)***:

C. Request for Review

A claimant whose application for benefits is denied in whole or in part shall have the right to file a request for review by the Trustees of the denied claim within 60 days (180 days for disability claims) of receipt of written notification of the denial of the claim.

All such appeals of the decision denying, in whole or in part, any claim, shall be referred by the Plan Office to the Trustees. The Chairman and Secretary may in their discretion appoint a subcommittee of one or more Trustees who shall be delegated to hear and determine the appeal. The appeal shall not defer to the initial benefit determination and shall consider all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination. The claimant may submit written comments, documents, records and other information relating to the claim, and shall, upon reasonable request and without charge have access to and copies of all documents, records, or other information relevant to the claim.

Prior to issuing a denial of an appeal of a claim involving disability, the Plan Administrator will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, and/or with any new or additional rationale for denying the claim, as soon as possible and sufficiently in advance of the date the appeal is to be considered to give the claimant a reasonable opportunity to respond prior to the date the appeal will be considered.

4. Article XVI, Section 7.D.(4) shall be amended to read as follows (***new language shown in bold italics***):

D. Decision on Appeal

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(4) A statement of the claimant's right to bring an action under Section 502(a) of ERISA following the appeal, ***including a description of any contractual limitations period that applies to the claimant's right to bring an action, including the calendar date on which the contractual limitation period expires for the claim.***

5. Article XVI, Section 7.D shall be amended to add new paragraphs (6) and (7) to the end thereof:

(6) In the case of an adverse determination involving disability benefits:

(a) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse determination, without regard to whether the advice was relied upon in making the determination; and

(iii) A disability determination regarding the claimant made by the Social Security Administration, if that determination was presented by the claimant to the Plan;

(b) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(c) A copy of the specific internal rules, guidelines, protocols, 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; and

(d) A statement that the claimant is entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(7) Any notice provided pursuant to paragraph (6) will be provided in a culturally and linguistically appropriate manner with a statement prominently displayed in any applicable non-English language, as defined in guidance published by the Secretary of Labor pursuant to 29 C.F.R. § 2560.503-1(o), clearly indicating how to access the language services provided by the Plan.

Adopted and Approved: February 21, 2018

Effective Date: April 1, 2018

H. Marshall Ainley, Chairman

Edward Hanley, Secretary