MEBA MEDICAL & BENEFITS PLAN
MEBA PENSION TRUST
MEBA TRAINING PLAN
MEBA VACATION PLAN

BENEFIT PLANS

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MEBA MEDICAL AND BENEFITS PLAN
SUMMARY OF MATERIAL MODIFICATIONS

This Summary of Material Modifications advises you of changes in the information contained in the MEBA Medical and Benefits Plan Summary Plan Description ("SPD"), as required by the Employee Retirement Income Security Act of 1974. The Trustees of the MEBA Medical and Benefits Plan (the "Plan") have amended the Plan to: (i) clarify the rules regarding a Participant's home of record; (ii) clarify that active Eligible Employees and their Dependents may receive basic dental services at the Oakland MEBA Diagnostic Center's Dental Clinic, and Pensioners and their Dependents may receive basic dental services at such clinic on a space-available basis; (iii) remove the limitation that vision therapy be a covered expense only if such therapy is provided in lieu of surgery, and include expenses for treatment prescribed by and performed by a Doctor of Optometry; (iv) clarify that overlap days count as days on the payroll in covered employment for purposes of establishing initial eligibility and maintaining continuing eligibility under the Plan; (v) modify the Plan's definition of "Legally Qualified Physician"; (vi) add coverage for services related to the treatment of Autism Spectrum Disorders; (vii) cover certain expenses for occupational therapy; and (viii) modify the Plan's claims and appeals procedures to comply with Department of Labor regulations related to claims and appeals for disability benefits. The SPD will be changed as described below:

HOME OF RECORD

Effective August 24, 2017, the Trustees amended the Plan with respect to the determination of a Participant's home of record, to clarify for this purpose, "United States" means the 50 states, the District of Columbia and Puerto Rico.

Accordingly, effective August 24, 2017, the second sentence under the "Home of Record" Subsection of the SPD Section entitled "Diagnostic Centers" on page 24 is revised to read as follows:

> If your primary residence is outside of the United States (for this purpose, "United States" means the 50 states, the District of Columbia and Puerto Rico), the Home of Record for the purpose of paying the travel reimbursement is deemed to be the airport included on a list designated by the Trustees of major Continental United States airports that is closest to your Home of Record.

OAKLAND MEBA DIAGNOSTIC CENTER DENTAL CLINIC

Effective January 1, 2017, the Trustees amended the Plan to clarify that active Eligible Employees and their Dependents may receive basic dental services at the Oakland MEBA Diagnostic Center's Dental Clinic; provided, in no event will a duplicate treatment be provided under the Plan. Pensioners and their Dependents may receive basic dental services at such clinic on a space-available basis. If the Trustees determine that an Eligible Employee or the Dependent of an Eligible Employee has received duplicate services, the costs of the duplicate services will be considered an overpayment under the Plan and the Eligible Employee will be required to reimburse the Plan in full for the cost of such duplicate services. Basic dental services do not include periodontal, orthodontia, or dental surgery. No co-pay or out-of-

pocket charge shall apply to basic dental services provided at the Oakland MEBA Diagnostic Center's Dental Clinic.

a. Accordingly, effective January 1, 2017, the following language is added at the end of the SPD Section entitled "Dental Benefits" on page 60:

Oakland MEBA Diagnostic Center's Dental Clinic

Notwithstanding anything in this Section to the contrary, active employees and their dependents may receive basic dental services at the Oakland MEBA Diagnostic Center's Dental Clinic; provided, in no event will a duplicate treatment be provided under the Plan. Pensioners and their dependents may receive basic dental services at such clinic on a space-available basis. If the Trustees determine that an active employee or the dependent of an active employee has received duplicate services, the costs of the duplicate services will be considered an overpayment under the Plan and the active employee will be required to reimburse the Plan in full for the cost of such duplicate services. Basic dental services do not include periodontal, orthodontia, or dental surgery. No co-pay or out-of-pocket charge shall apply to basic dental services provided at the Oakland MEBA Diagnostic Center's Dental Clinic.

b. Accordingly, effective January 1, 2017, the "Dental Benefit" Subsection of the SPD Section entitled "Medical Coverage for Pensioners and Their Dependents" on page 48 is revised to read as follows:

Dental Benefit

The Plan provides no dental or orthodontia benefits for persons with pensioner coverage including their dependents; however, pensioners and their dependents may receive basic dental services at the Oakland MEBA Diagnostic Center's Dental Clinic on a space-available basis.

VISION THERAPY

Effective June 1, 2017, the Trustees amended the Plan with respect to expenses for vision therapy as a Covered Medical Expense to: (i) remove the limitation that vision therapy be a covered expense only if such therapy is provided in lieu of surgery; and (ii) include expenses for treatment prescribed by and performed by a Doctor of Optometry. Expenses for vision therapy that otherwise meet the criteria as a Covered Medical Expense will not be capped with respect to the number of visits.

a. Accordingly, effective June 1, 2017, the 10th bullet under the SPD Section entitled "Charges for Other Services and Supplies" on page 23 is revised to read as follows (deleted language in ~~strikethrough~~):

- Vision therapy~~, provided (i) the condition can be corrected surgically and (ii) therapy is being performed in lieu of surgery~~;

b. Accordingly, effective June 1, 2017, the following language is added at the end of the SPD Section entitled "Legally Qualified Physician" on page 12:

For purposes of vision therapy, a duly licensed Doctor of Optometry is deemed to be a Legally Qualified Physician acting within the scope of his/her license.

OVERLAP DAYS

At their May 24, 2017 meeting, the Trustees amended the Plan to clarify that overlap days count as days on the payroll in covered employment for purposes of establishing initial eligibility and maintaining continuing eligibility under the Plan.

Accordingly, effective May 24, 2017, the following language is added at the end of the first paragraph under the SPD Section entitled "Who is Eligible" on page 5:

> Notwithstanding anything in this Section to the contrary, for purposes of establishing initial eligibility and maintaining eligibility, "overlap days" count as days on the payroll in covered employment. An "overlap day" occurs when an employee who first reports to work aboard a vessel and the employee being relieved are both required to work on, and are paid a shipboard wage for, that same day, regardless of whether contributions are paid on behalf of such employee for that day.

LEGALLY QUALIFIED PHYSICIAN

Effective June 1, 2016, the Trustees amended the Plan to modify the definition of "Legally Qualified Physician" and to replace the term "Legally Qualified Physician" with the term "Licensed Qualified Provider."

a. Accordingly, effective June 1, 2016, all references in the SPD to "Legally Qualified Physician" are replaced with "Licensed Qualified Provider."

b. Accordingly, effective June 1, 2016, the SPD Section entitled "Legally Qualified Physician" on page 12 is revised to read as follows:

Licensed Qualified Provider

Except as specifically stated otherwise in this SPD or the Rules and Regulations, the Medical Plan only covers services provided by a Licensed Qualified Provider. A Licensed Qualified Provider is a person who is a duly certified and licensed (1) physician, chiropractor, psychologist, psychiatrist, social worker, podiatrist, physical therapist, occupational therapist, licensed midwife, speech-language pathologist, licensed nurse practitioner, licensed physician's assistant or any other licensed and certified health care provider; (2) with respect to the coverage of nervous and mental disorders, any mental health practitioner who is either licensed or certified by the State in which he/she practices. All providers must operate within the scope of their license for a benefit to be covered and some benefits are subject to maximum visit limits. For purposes of the vision therapy benefit under the Plan, a duly licensed Doctor of Optometry is deemed to be a Licensed Qualified Provider when acting within the scope of his/her license.

AUTISM SPECTRUM DISORDERS

Effective June 1, 2016, the Trustees amended the Plan to add coverage for services related to the treatment of Autism Spectrum Disorders.

a. Accordingly, effective June 1, 2016, the fifth bullet under the "Charges for Other Services and Supplies" Subsection of the SPD Section entitled "Covered Expenses for Active

Employees" on page 22 is revised to read as follows:

- Chiropractic treatment, x-ray therapy, physiotherapy or physical therapy under the supervision of a Licensed Qualified Provider. Chiropractic treatment, physiotherapy, and physical therapy are limited to 40 visits in a two-year period combined, but this limit does not apply for physiotherapy or physical therapy treatment following a stroke or a radical mastectomy, or if used as treatment for multiple sclerosis or a condition caused by multiple sclerosis;

b. Accordingly, effective June 1, 2016, the first sentence of the seventh bullet under the "Charges for Other Services and Supplies" Subsection of the SPD Section entitled "Covered Expenses for Active Employees" on page 22 is revised to read as follows:

- speech therapy by a qualified speech-language pathologist, provided the speech impairment is caused by injury or disease;

c. Accordingly, effective June 1, 2016, the following language is added at the end the "Charges for Other Services and Supplies" Subsection of the SPD Section entitled "Covered Expenses for Active Employees" on page 23:

- Screening, diagnosis and treatment of Autism Spectrum Disorders for qualified dependents under age 7. These treatments may include necessary assessments, evaluations and testing to determine whether an individual has one or more Autism Spectrum Disorders. "Autism Spectrum Disorders" means a range of conditions characterized by challenges or deficits with social skills, repetitive behaviors, speech and nonverbal communications, as well as by unique strengths and differences caused by different combinations of genetic and environmental influences.
- Behavioral health treatments such as professional, counseling, guidance services and treatment programs, including Applied Behavioral Analysis (ABA) when provided by a board certified behavior analyst licensed by the applicable state board of medicine. The ABA services are subject to an annual maximum of $35,000 and are for qualified dependents under age 7 necessary to develop, maintain, or restore the functioning of the qualified dependent. "Applied Behavior Analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- Outpatient speech therapy, occupational therapy, and physical therapy for qualified dependents under age 7 who are diagnosed with Autism Spectrum Disorder when prescribed and provided by a Licensed Qualified Provider.

OCCUPATIONAL THERAPY

Effective January 1, 2017, the Trustees amended the Plan to include expenses for occupational therapy as a Covered Medical Expense when prescribed and performed by a Licensed Qualified Provider for treatment of dependent children under age 7, but not to exceed when combined with the physical therapy benefit under the Plan, a maximum of 30 visits per person annually.

Accordingly, effective January 1, 2017, the following language is added at the end the "Charges for Other Services and Supplies" Subsection of the SPD Section entitled "Covered Expenses for Active Employees" on page 23:

- Occupational therapy prescribed and performed by a Licensed Qualified Provider for treatment of qualified dependents under age 7, but not to exceed when combined with the physical therapy benefit under the Plan, a maximum of 30 visits per person annually.

DISABILITY CLAIMS AND APPEALS

Effective April 1, 2018, the Trustees amended the Plan to comply with Department of Labor regulations related to claims and appeals for disability benefits.

a. Accordingly, effective for claims for disability benefits filed on or after April 1, 2018, the following language is added at the end of the SPD Section entitled "If A Medical Plan Claim For Benefits Or Application Is Denied" on page 62:

Initial Disability Claim Denial Involving Discretionary Determination of Disability by the Plan

In the case of a denial of your claim for disability benefits that is based on a determination by the Plan (and not by a third party acting independent of the Plan such as the Social Security Administration ("SSA")), that you are not disabled under the Plan rules, the Plan Office will provide you with a written notice of the denial that also contains the following information:

- A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following:
  - The views you presented to the Plan of health care professionals treating you and vocational professionals who evaluated you (if any);
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination, even if the advice was not relied upon in making the benefit determination; and
  - A disability determination made by the SSA, if you provided it to the Plan;
- 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 your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- 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;
- A statement that you are entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement regarding your right to bring a civil action under ERISA Section 502(a).

The written notice of denial will be provided in a culturally and linguistically appropriate manner clearly indicating how to access the language services provided by the Plan, if this applies to your claim. Additionally, a denial of your claim also includes a rescission of your

disability coverage, unless it is attributable to a failure to timely pay required premiums of contributions towards the cost of coverage.

b. Accordingly, effective for claims for disability benefits filed on or after April 1, 2018, the following language is added at the end of the SPD Section entitled "Determination on Appeal" on page 66:

Disability Decision on Appeal Involving Discretionary Determination of Disability by the Plan

Prior to issuing a denial of an appeal of a claim for a disability benefit that is based on a determination by the Plan (and not by a third party acting independent of the Plan such as the SSA)), that you are not disabled under the Plan rules, the Plan Office will provide you, 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, to the extent possible, sufficiently in advance of the date the appeal is to be considered to give you a reasonable opportunity to respond prior to the date the appeal will be considered.

In the case of a denial of your appeal involving this type of disability benefits, you will receive a written notice of the denial that includes all of the information in the SPD subsection entitled "Initial Disability Claim Denial Involving Discretionary Determination of Disability by the Plan," as well as the calendar date on which the contractual limitations period expires for the claim.

If you have any questions regarding these changes, call the Plan Office's Member Services Department at 410-547-9111 or 800-811-6322. Keep this notice with your SPD so that when you refer to the SPD, you will be reminded of the above changes.

Ann S. Gilchrist, Administrator