RULES AND REGULATIONS PROVIDING BENEFITS OF THE MEBA MEDICAL AND BENEFITS PLAN

(Amended and Consolidated through Amendment No. 23-4) 06/15/23

ARTICLE I

ELIGIBILITY

1. Except as otherwise set forth herein, in order to maintain eligibility under the Plan as an Active Participant, an Employee who currently or previously has obtained eligibility for benefits under the Plan must complete sixty (60) days on the payroll in covered employment with one or more Employers within any period of six consecutive calendar months.

   In order to establish initial eligibility under the Plan, Employees who have not previously participated in the Plan ("new entrants") must complete thirty (30) days on the payroll in covered employment with one or more Employers within any period of six consecutive calendar months. After establishing initial eligibility under the Plan, during the year after their first date of covered employment, new entrants will maintain eligibility for benefits after completing a second period of thirty (30) days on the payroll in covered employment within any period of six consecutive calendar months. Thereafter, the sixty (60) days in six month rule for maintaining eligibility described in the first paragraph hereof shall apply. Notwithstanding anything herein to the contrary, for purposes of establishing initial eligibility and maintaining eligibility, "overlap days" shall 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.

   An Employee who has become eligible as set forth above may retain eligibility during service with an entity that is not an Employer but that contributes to this Plan with respect to such Employee if such Employee is on a recognized leave of absence from covered employment with District No. 1-Pacific Coast District, MEBA.

   Days of attendance at the Calhoon MEBA Engineering School shall count for purposes of determining eligibility for Plan benefits provided the Employee is not receiving a benefit from the MEBA Vacation Plan or receiving wages from an Employer.

   Days of attendance at the Maritime Institute of Technology & Graduate Studies ("MITAGS") on and after January 1, 2021 shall count for purposes of determining eligibility for Plan benefits provided the Employee is a mate and is not receiving a benefit from the MEBA Vacation Plan or receiving wages from an employer.

   Notwithstanding the foregoing, an Active Participant who was totally disabled must complete thirty (30) days on the payroll in covered employment within any period of six consecutive calendar months in order to maintain eligibility under the Plan. Such Active Participant will become subject to the sixty (60) day rule upon his recovery from total disability and resumption of active employment.

2. For the purpose of determining an Employee's eligibility for any Plan benefits, days of disability shall be treated as follows:

   Days of disability shall not count as days on an Employer's payroll for the purpose of establishing eligibility hereunder. However, if an Employee has established eligibility in accordance with Section 1 of this Article 1 and such Employee becomes totally disabled

while eligible for benefits hereunder, eligibility shall continue so long as the Employee remains totally disabled, but not to exceed a period of eighteen (18) months from:

(a) the last day of covered employment (i.e. the date of disability), if the disability occurs while actively employed;

(b) the last day of the vacation period if the disability occurs while on a vacation period immediately following covered employment (for which the Employee filed prior to the disability);

(c) the last day of the vacation period that immediately followed covered employment if the disability occurs subsequent to the last day of the vacation period immediately following covered employment (for which the Employee filed prior to the disability)."

3. Termination of Coverage

(a) An Employee's eligibility for benefits hereunder, and corresponding coverage, shall terminate on the earliest of the following dates:

1) The last day of the six (6) consecutive month period immediately following the last day of covered employment used to establish eligibility under Section 1 of this Article I; provided that eligibility shall continue in the event of total disability as outlined in Section 2 of this Article I. Such termination shall not prevent completion of payment under Article VI, even though eligibility may have terminated under this subsection.

2) The date the Employee becomes eligible for benefits under any other health, medical insurance or similar welfare plan established between the Union and Employers; provided, however, that said termination shall be subject to the provisions of any reciprocal agreement that may be outstanding between the Plan and any such other plan.

3) The date the Employee enters the military, naval or air forces of any country, state or union (or association thereof).

4) The date the Employer with whom the Employee is employed, ceases to be obligated under any collective bargaining agreement with the Union to make the required contributions to the Plan; provided, however, that if as of said date an Employee is eligible for benefits, such eligibility shall not terminate until six (6) consecutive months following the Employee's last date of covered employment used to establish eligibility under Section 1 of this Article I.

5) In the case of a cadet engineer who has withdrawn from the Cadet Program at the Calhoon MEBA Engineering School prior to completion of such program, the last day of the month during which such withdrawal occurs.

6) The date on which the Eligible Employee fails to complete 60 days on the payroll in covered employment with one or more Employers within any period of six consecutive calendar months.

(b) Notwithstanding the preceding, coverage or benefits may continue if and to the extent provided for each benefit under an applicable insurance contract, policy or the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA coverage").

(c) If an Eligible Employee and/or his eligible Dependents experience an event that makes such person ineligible to continue coverage under the Plan, the Eligible Employee is required to notify the Plan Office in writing within 30 days of the event that impacts continuing eligibility

under the Plan. Failure to report such event within 30 days may result in the Eligible Employee reimbursing the Plan for claims paid under the Plan after the event causing termination of coverage. Events that must be reported to the Plan Office and may lead to ineligibility and loss of coverage include but are not limited to the following:

1) divorce;

2) legal separation;

3) eligibility for other medical coverage;

4) a stepchild or grandchild's change in marital status, change in student status, change in residency or change in custody or support;

5) a grandchild's failure to meet the grandchild eligibility requirements described in the definition of Dependent under Article XVIII; and

6) a parent's failure to meet the rules established by the Trustees.

(d) Notwithstanding the foregoing, medical benefits shall not be cancelled or discontinued with a retroactive effect with respect to an Eligible Employee or Dependent except in the event of fraud or intentional misrepresentation or termination for non-payment of a required premium.

(e) Notwithstanding anything herein to the contrary, upon submission of a voluntary application and election, an eligible Dependent Spouse may be permitted to withdraw from further coverage under the Plan provided the following conditions are met:

1) The Dependent Spouse executes before a Notary or Plan employee a written application and election to withdraw from coverage under the Plan;

2) Once an application and election to withdraw from coverage is received by the Plan, the application and election to withdraw can only be revoked in writing before a Notary or Plan employee;

3) The Dependent Spouse's future coverage under the Plan will be effective on the first day of the month following the Plan's receipt of a written revocation of the application and election to withdraw from coverage;

4) The Dependent Spouse's application and election to withdraw from coverage under the Plan must acknowledge that the withdrawal is entirely voluntary and, further, acknowledges his or her understanding and acceptance of all of the conditions applicable to this subsection.

4. In the event of the death of an Eligible Employee, Dependent benefits under the Plan shall continue for up to five (5) consecutive calendar months following the month in which his death occurred.

5. Notwithstanding any other provision hereof to the contrary, an Employee's eligibility for benefits shall continue during any leave of absence approved by his Employer pursuant to the Family and Medical Leave Act.

6. Notwithstanding any other provisions to the contrary, for an individual who is not an Eligible Employee or Dependent but is a registered individual seeking employment with an Employer and a physical is required in order to ship; the Plan will cover the expense of an annual physical exam conducted at a

MEBA Diagnostic Center. The Plan will also cover expenses for blood work, tests and vaccinations necessary to ship conducted at a MEBA Diagnostic Center (including benzene certification and mariner-required vaccinations including, but not limited, to: COVID-19, MMR, polio, tetanus, varicella, hepatitis A, typhoid, yellow fever, influenza and smallpox).

ARTICLE II

BENEFICIARIES

1. Each Eligible Employee shall have the right to designate a beneficiary or beneficiaries to receive benefits hereunder payable by reason of his death and any benefits payable to such Employee accrued prior to his death, but such designation shall not be valid unless it is in writing, on forms supplied for that purpose by the Trustees (or satisfactory to the Trustees), on file at the principal office of the Trustees in Baltimore, Maryland. The beneficiary or beneficiaries so designated shall be known as the beneficiary or beneficiaries of record.

2. The beneficiary or beneficiaries of record first designated by the Eligible Employee shall continue to be the beneficiary or beneficiaries of record for the aforesaid benefits (including any increase in such benefits becoming effective with respect to such Eligible Employee subsequent to such designation) unless and until such initial designation is effectively revoked or changed by the Eligible Employee. In the event of an effective revocation which is not accompanied or followed by a new valid designation of one or more beneficiaries, such benefits shall be payable, as set forth below, as though no beneficiary has been designated. In the event of a valid change of beneficiary or beneficiaries of record, the new beneficiary or beneficiaries shall be considered the beneficiary or beneficiaries of record as though initially designated and such designation shall continue until validity is revoked or changed.

3. An Eligible Employee may from time to time revoke or change any designation of beneficiary or beneficiaries by filing written notice of such revocation or change or by a new designation of beneficiary on forms supplied for that purpose by the Trustees (or satisfactory to the Trustees) at the principal office of the Trustees in Baltimore, Maryland. However, such written notice of revocation, change, or designation of a new beneficiary shall not be deemed valid unless it is received at the said office of the Trustees prior to the earliest date that any payment is made by the Trustees of all or any portion of the benefits payable with respect to said Eligible Employee. Upon the receipt of such valid written notice at said office, the revocation or change shall relate back to take effect as of the date the Eligible Employee signed said written notice of revocation or change, whether or not the Eligible Employee be living at the time of receipt of said notice.

4. If more than one beneficiary is validly designated, and in such designation the Eligible Employee has failed to specify their respective interests, the beneficiaries shall share equally. In the event that any beneficiary of record does not survive the Eligible Employee, the interest of such beneficiary shall terminate and his share shall be payable equally to such of the beneficiaries as survive the Eligible Employee, unless the Eligible Employee has filed a written request with the Trustees to the contrary.

5. The amount of any benefit for which there is no beneficiary at the death of the Eligible Employee (either because no beneficiary of record survived the Eligible Employee or no beneficiary shall have been designated) shall be paid to the executors or administrators of the Eligible Employee; provided, however, that the Trustees may, in their sole discretion, pay the entire amount of such benefits to the Eligible Employee's spouse if then living, or if there is no surviving spouse, to any other person who the Trustees determine to be an object of the natural bounty of the Eligible Employee. If payment is made in accordance with the foregoing provision, the Trustees shall be completely discharged of liability with respect to the amount of benefits so paid.

6. If any beneficiary of record is a minor or is otherwise incapable of giving a valid release for any payment due, the Trustees may, at their discretion and until claim is made by the duly appointed guardian or committee of such beneficiary, make payment of the amount of the benefit to such beneficiary, at a rate not exceeding $50 per month, to any relative by blood or connection by marriage of such beneficiary, or to any other person or institution appearing to them to have assumed custody and principal support of such beneficiary, for the sole benefit of such beneficiary. Such payment shall constitute a full discharge of the obligations of the Trustees to the extent thereof.

7. ***Facility of Payment***. The Trustees may, at their sole discretion, deduct from the sum payable at the time of the death of an Eligible Employee or Pensioner an amount to be paid to any person or persons, other than the Trustees of the Plan, who appears to the Trustees to be equitably entitled to the payment by reason of having incurred expenses on behalf of the Eligible Employee for his burial. The amount of the payment to be deducted shall be equal to the lesser of:

   (a) The actual expense incurred; or
   (b) The amount of the Life Benefit; or
   (c) $1,000.00

   The liability of the Trustees shall thereby be completely discharged to the extent of the amount so paid.

8. A beneficiary hereunder shall not include any Trustee of the Plan or employees thereof, the Union or any Employer.

ARTICLE III

LIFE BENEFIT

1. Subject to the terms and conditions applicable to this coverage, upon receipt of due proof at the principal office of the Trustees of the death of an Eligible Employee by any cause other than a risk or peril which is excluded hereunder, the Trustees shall pay to his beneficiary or beneficiaries the amount of the Life Benefit in force hereunder in accordance with Schedule A hereof. If an Eligible Employee for the Life Benefit under Schedule A has 400 days of covered employment in the three (3) calendar years immediately preceding the calendar year in which the death occurred, the Trustees shall, in addition thereto, pay to the beneficiary or beneficiaries, the amount of the Life Benefit in force hereunder in accordance with Schedule B hereof; provided, however, that the aforementioned 400-day requirement shall be waived and the amount of the Life Benefit in force in accordance with Schedule B hereof shall also be payable in the case of an Eligible Employee whose death occurs as a result of bodily injuries sustained solely through external, violent and accidental means in the course of covered employment (excluding days of vacation), directly and independently of all other causes within ninety (90) days from the date of such injuries.

2. In order that the assets of the Fund shall not be unduly depleted, the Trustees expressly limit their liability in cases where certain other insurance is payable to any beneficiaries of a seaman. For example, no Life Benefit shall be payable under this Article III in the event of death resulting from a risk or peril for which benefits are payable under a policy provided for seaman by the United States Government or a policy carried (or a self-insurance program maintained), by an Employer in compliance with a collective bargaining agreement with the Union, provided such benefits are payable by reason of shipping operations or as a result of an act of war, or under wartime conditions. This provision shall be deemed to include a policy or program providing benefits substantially the same as those in the policy commonly known as the Second Seaman's War Risk Policy.

   As an exception to this rule, it is provided that the Life Benefit shall nevertheless be payable in the event of a death of an Eligible Employee, who has at least ten (10) years of covered employment, as a result of an act of war, declared or undeclared, or under wartime conditions and the surviving spouse, or child under 21 years of age, of the deceased Eligible Employee is not eligible to receive a pension benefit under Article IV of the MEBA Pension Trust Regulations.

3. ***Continuation of Life Benefit Coverage in the Event of Continuous and Total Disability***

   (1) An Eligible Employee shall continue to retain eligibility for the Life Benefit provided in Section 1 of this Article III, even though his eligibility for any other benefits hereunder is terminated under other provisions of the Plan, provided that each of the following conditions are satisfied:

      (a) the Eligible Employee becomes totally and permanently Disabled as a result of bodily injury or disease which prevents such Employee from engaging in any business or occupation and from performing any work for compensation or profit, provided the bodily injury or disease did not result from a risk or peril for which benefits are payable under a Seaman's War Risk Insurance Policy;

      (b) such Disability is continuous until the death of the Eligible Employee;

      (c) the Eligible Employee becomes disabled, as defined in subparagraph (a) above, before attaining age 60;

      (d) the Eligible Employee furnishes the Trustees at their principal office, after nine (9) months following the date the Eligible Employee becomes Disabled, as defined in subparagraph (a)

above, but within twelve (12) months following the date of termination of the Eligible Employee's eligibility, written proof that he is permanently and totally Disabled as defined in subparagraph (a) above and has been so Disabled continuously since the date he incurred such Disability. At the time the Eligible Employee furnishes such proof of Disability, the Trustees shall certify acknowledgement of receipt of said proof and the date upon which it was received , such date to be referred to as the Original Date of Certification;

(e) the Eligible Employee furnishes the Trustees at their principal office with written proof of continued permanent and total Disability within the three (3) months immediately prior to each anniversary of the Original Date of Certification during the life of the Eligible Employee. The Trustees will certify to the Eligible Employee each year when such proof of continued permanent and total Disability is furnished; and

(f) written notice of the Eligible Employee's death is furnished to the Trustees at their principal office within one (1) year of the death of the Eligible Employee. In the event of death of the Eligible Employee within one (1) year from the date of termination of his eligibility, and before any such proof of Disability has been submitted, written proof that the Eligible Employee was continuously Disabled from said date to the date of death shall be furnished to the Trustees within one year after the death of said Eligible Employee.

(2) The Trustees shall have the right to have any Eligible Employee who submits proof of Disability in accordance with this Article examined at any time by physicians designated by them; provided, that after such Disability shall have continued for two (2) full years, such examination shall not be required more often than once in each subsequent year.

(3) All rights of an Eligible Employee under this Section 3 shall cease on the earliest to occur of the following dates;

(a) the date of cessation of the Eligible Employee's permanent and total Disability;

(b) the date the Eligible Employee engages in any business or occupation or performs any work for compensation or profit, whether or not the Eligible Employee continues to be permanently and totally Disabled;

(c) the last day of any twelve-month period of continued eligibility under this Section 3, if the proof of Disability required by Section 3, subparagraph (1)(e) of this Article III is not furnished within the three (3) month period specified therein;

(d) the date on which the Eligible Employee refuses to submit to examination by physicians designated by the Trustees, upon their request;

(e) the date the Eligible Employee qualifies for a pension under the MEBA Pension Trust Regulations or the District 2 MEBA-AMO Pension Plan; or

(f) the last day of the period (commencing with the date the Eligible Employee first becomes totally and permanently Disabled) which equals the number of years of pension credit that the Eligible Employee has accrued as of the date he became totally and permanently Disabled, provided that such period shall not exceed 9-11/12 years.

(4) No judicial proceedings shall be brought to enforce the right of any Eligible Employee to coverage under this Section 3 unless brought within two (2) years after the Trustees refuse to determine and certify that such Employee is entitled to rights on account of permanent or total Disability.

(5) In the event an Eligible Employee dies while outside the continental United States, the Trustees, in their sole discretion, may authorize reimbursement in an amount not to exceed $1,000 for transportation and other incidental expenses necessarily incurred by the beneficiary or other member of the family in returning the body of the decedent to the United States. This benefit may be over and above any other Life Benefit.

ARTICLE IV

INSURANCE FOR DEATH AND DISMEMBERMENT BY ACCIDENTAL MEANS

1. If an Eligible Employee suffers any of the losses described in Section 2 of this Article IV, as a result of bodily injuries sustained solely through external, violent and accidental means, directly and independently of all other causes, within ninety (90) days from the date of such injuries, the Trustees shall pay to the Eligible Employee (if living, otherwise to the beneficiary), the amount of the benefit specified for such loss in Section 2 of this Article IV, determined on the basis of the full amount of the benefit set forth in Schedule C and, in addition thereto, the full amount of the benefit set forth in Schedule D, provided he had four hundred (400) days of covered employment in the three (3) consecutive calendar years immediately preceding the calendar year in which the injury occurred that resulted in such death or dismemberment; provided, however, that no payment shall be made for any loss caused wholly or partly, directly or indirectly by:

   (a) Disease, bodily or mental infirmity, or medical or surgical treatment thereof;

   (b) Ptomaines, or bacterial infection, except infection introduced through a visible wound accidentally sustained;

   (c) Suicide while sane or insane, or intentionally self-inflicted injury; or

   (d) War, or any act of war, whether declared or undeclared. As an exception to this rule, the Accidental Death Benefit shall nevertheless be payable in the event of the death of an Eligible Employee, who has at least ten (10) years of covered employment, as a result of an act of war, declared or undeclared, or under wartime conditions and the surviving spouse, or child under 21 years of age, if the deceased Eligible Employee is not eligible to receive a pension benefit under Article IV of the MEBA Pension Trust Regulations.

2. ***Schedule of Indemnities***

   (a) The full amount of the benefit shall be payable for one or more of the following losses:

   Life
   Both hands
   Both feet
   One hand and one foot
   Sight of both eyes
   One hand and sight of one eye
   One foot and sight of one eye
   Sight of one eye

   (b) One-half of the full amount of the benefit shall be paid for one or more of the following losses:

   One hand
   One foot

   (c) Loss of hands or feet shall mean loss by severance at or above the wrist or ankle joint, and loss of sight shall mean total and irrevocable loss of sight.

   (d) If an Eligible Employee shall suffer more than one of the losses described above as a result of any one accident, no more than the full amount of the benefit shall be payable.

3. If an Eligible Employee suffers any of the losses described in Section 2 of this Article IV as a result of bodily injuries sustained solely through external, violent and accidental means in the course of covered employment, directly and independently of all other causes, within ninety (90) days from the date of such injuries, the Trustees shall pay to the Eligible Employee (if then living, otherwise to the beneficiary), the amount of the benefit specified for such loss in Section 2 of this Article IV, determined on the basis of the full amount of the benefit set forth in Schedules C and D, provided, however, that no payment shall be made for any loss caused wholly or partly, directly or indirectly by any risk or peril which is excluded under Articles III and IV hereof. For the purpose of this Section 3, the term "covered employment" shall not include days of vacation.

ARTICLE V

DISABILITY BENEFITS FOR ELIGIBLE EMPLOYEES

1. When physical or mental Disability shall make an Eligible Employee unfit to perform his normal duties as a licensed officer, and shall require the regular care and attendance of a licensed physician or surgeon, the Eligible Employee shall receive a Disability benefit equal to one-seventh of the weekly benefit set forth in Schedule E for each calendar day during which he is so unfit for duty; provided, however, that he satisfies each of the following conditions:

   (a) He has been so unfit for duty for a waiting period of seven (7) consecutive days during each Disability period, as established by the Trustees, during which waiting period no benefits shall be payable, except that Disability benefits shall commence in any event upon the day he is confined to a hospital;

   (b) The maximum payment hereunder shall not exceed thirty-nine (39) weeks of Disability benefits as provided in Schedule E;

   (c) He has submitted to such reasonable examinations to determine his Disability as may be required by the Trustees;

   (d) No benefits or credit for waiting period shall be given for any period during which the Eligible Employee is on the payroll of an Employer, except in the case of an Eligible Employee on vacation who is Disabled for a condition which requires hospitalization; provided, however, that if Disability occurs during the time such officer is on such payroll, including vacation time, days of employment shall count for the waiting period; and

   (e) Where an Eligible Employee is entitled to payments for Disability or as Workmen's Compensation under the laws of any State, the Eligible Employee shall receive daily for a period of thirty-nine (39) weeks only the difference, if any, by which 1/7 of the weekly benefits provided in Schedule E are greater than the daily payment under State law for that day.

2. The Trustees shall adopt other and further rules with respect to Disability benefits, consistent with the Plan that shall be binding on all parties.

3. The Trustees reserve the right, on an equitable basis, to deny Disability benefits in any case where there is reasonable evidence that the Plan and the Eligible Employees would be prejudiced by claims for Disability that do not accord with equitable principles, or in any case where an Eligible Employee appears to make claims inconsistent with Disability and employment.

ARTICLE VI

MAJOR MEDICAL EXPENSE COVERAGE FOR ELIGIBLE EMPLOYEES AND DEPENDENTS

1. Major Medical Expense Benefits

(a) Except as provided in Sections 3(e) (1), 3(f), (g) (ii) and (h) of this Article VI, if an Eligible Employee or his Dependent incurs a Covered Medical Expense (as defined herein) other than a Hospital Expense (as defined herein), as a result of an accidental bodily injury or disease, a benefit shall be payable to the Eligible Employee in an amount equal to 60% of such Expense. Notwithstanding the preceding sentence, Covered Medical Expenses described in Sections 3(e)(14) thru (17) and Section 3(e)(24) and Sections 3(e) (28) -(34) shall be payable in an amount equal to 100% of such Expense up to the specified dollar limit.

(b) Except as noted in Sections 3 (f) (g) (i) and (h) of this Article, if an Eligible Employee or his Dependent incurs a Hospital Expense (as defined herein) as a result of an accidental bodily injury or disease, a benefit shall be payable to the Eligible Employee in an amount equal to 60% of such Expense, subject to an Annual Deductible in accordance with Schedule G hereof. The applicable Deductible Amount may be satisfied by the Eligible Employee and his Dependent(s) only by incurring, within the calendar year, Hospital Expenses (as defined herein), in an amount equal to said Deductible Amount.

(c) For purposes of this coverage, a Covered Medical Expense is incurred on the date on which the Eligible Employee or Dependent receives or is furnished the services or supplies in connection with such expense.

(d) During the period of eligibility of an Eligible Employee, any benefits available under this Article VI to the Eligible Employee or Dependent while such Employee or Dependent is eligible for benefits under the Federal Medicare Program shall be paid as a supplement only to the benefits payable under such Program whether or not such benefits are received. An Eligible Employee or Dependent who would be eligible for benefits under the Federal Medicare Program except for the fact that such Eligible Employee or Dependent resides outside the United States shall be deemed, for the purpose of this section, to be eligible for such benefits. Unless the Eligible Employee elects otherwise, benefits under this Article VI shall not be supplemental in the case of an Eligible Employee (or Dependent spouse) age 65 or over.

2. ***Definitions under Article VI***

For the purpose of this coverage, the following terms shall have the meanings set forth below:

(a) *"Hospital"* shall mean:

(1) an institution that is accredited as a hospital under the Hospital Accreditation Program of the Joint Committee on Accreditation of Hospitals; or

(2) any other institution, operated pursuant to law, under the supervision of a staff of Licensed Qualified Providers that offers twenty-four (24) hour a day nursing service, and which is primarily engaged in providing:

(a) general inpatient medical care and treatment of sick and injured persons through medical and diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control, or

(b) specialized inpatient medical care and treatment of sick and injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement with a Hospital (as defined above) or with a specialized provider of those facilities.

(3) an approved ambulatory surgical center (but only for purposes of covering outpatient hospital-type services related to surgical procedures).

(4) in no event shall the term "Hospital" include a convalescent nursing home or an institution or part thereof which (a) is used principally as a rest facility, custodial facility or facility for the aged, (b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living, or (c) is operated primarily as a school.

(5) with respect to the benefits described in Section 3(h) of this Article VI (for Eligible Employees only), a residential treatment center, provided the residential treatment center is a PPO provider.

(b) *"Surgery"* shall mean a cutting operation, treatment of fracture, reduction of a dislocation, endoscopic procedure, or injection treatment of hernia, hemorrhoids or varicose veins.

(c) *"Allowable"* charge for any service or supply shall mean the lowest of: (a) the usual charge of the provider for the service or supply (in the absence of the coverage provided hereunder), but not more than the prevailing charge in the area for a like service or supply; (b) the maximum amount that the Plan has determined it will pay for such service or supply: (c) the provider's actual charge for such service or supply; or (d) with respect to a provider that is party to an agreement with the Plan or a provider to the Plan to provide services to Eligible Employees and their Dependents, the charge agreed to by the provider under such agreement. A *"like service"* shall be of the same nature and duration, requiring the same skill, and performed by a provider of similar training and experience. A *"like supply"* is one that is identical or substantially equivalent. *"Area"* means the municipality (or, in the case of a large city, the subdivision thereof) in which the service or supply is actually provided or such greater area as is necessary to obtain a representative section of charges for a like service or like supply. A charge shall not be considered Allowable to the extent that it exceeds an amount that would be accepted by the provider of services, as payment in full, from any other source of coverage.

(d) *"Licensed Qualified Provider"* means only 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, 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; (3) with respect to Alcohol, Drug and Other Substance Abuse Benefits, a substance abuse professional who satisfies the requirements for certification under 49 CFR Part 40 Section 40.283. 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. A licensed nurse practitioner or licensed physician's assistant is deemed to be a Legally Qualified Provider when acting within the scope of his/her license.

(e) *"Covered Medical Expense."* Subject to the provisions of Section 4 of this Article VI, charges incurred by an Eligible Employee or Dependent for any of the services or supplies listed in the list of Covered Medical Expenses below, which are medically necessary and Allowable for the care and treatment of an injury or disease and which are furnished by or upon the recommendation and approval of a Licensed Qualified Provider, shall be considered Covered Medical Expenses to the

extent that such charges are not in excess of the amounts that would have been charged in the absence of this coverage.

(f) *"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.

(g) *"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.

(h) "*Gene Therapy"* means a Medically Necessary nonexperimental technique approved by the Food and Drug Administration that uses human genes to treat or prevent disease in humans that involves introducing human DNA, which contains a functioning gene to correct the effects of a disease-causing mutation, into an individual to replace or correct the effects of a disease-causing mutation. Non-human gene therapy does not constitute Gene Therapy.

(i) *"Ancillary Services"* shall mean, with respect to a participating Health Care Facility:

(1) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,

(2) Items and services provided by assistant surgeons, hospitalists, and intensivists;

(3) Diagnostic services, including radiology and laboratory services and subject to exceptions specified by federal regulation; and

(4) Items and services provided by a non-PPO provider if there is no PPO provider who can furnish such item or service at such participating Health Care Facility.

(j) *"Cost Sharing" or "Cost Share"* shall mean the amount an Eligible Employee, Pensioner, or their Dependent(s) (each a, "Covered Individual") is responsible for paying for a Covered Medical Expense under the terms of the Plan. Cost Sharing generally includes copayments, coinsurance, and amounts paid towards Deductibles, but does not include amounts paid towards premiums, balance billing by non-PPO providers, or the cost of items or services that are not covered under the Plan. Effective January 1, 2022, a Covered Individual's Cost Share applicable to No Surprises Services is based on the lesser of the Qualifying Payment Amount payable for such services or the amount billed by the non-PPO provider. Co-Insurance amounts paid for No Surprises Services will count towards a Covered Individual's PPO Annual Deductible, as detailed in Schedules G and J, and any applicable PPO Out-of-Pocket Maximums, as may apply under Schedule L, but not non-PPO Annual Deductibles or non-PPO Out-of-Pocket Maximums.

(k) *"Independent Freestanding Emergency Department"* shall mean a health-care facility that is geographically separate and distinct from a Hospital under applicable state law and that is licensed under state law to provide Emergency Services.

(l) *"Emergency Medical Condition*" means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine

could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(m) *"Emergency Services"* shall mean with respect to an Emergency Medical Condition:

(1) An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(2) Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the Eligible Employee or Dependent (regardless of the department of the hospital in which such further examination or treatment is furnished).

(3) Services provided by an out-of-network provider or facility after the Covered Individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:

A. The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;

B. The Covered Individual is supplied with a written Notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any PPO providers at the facility who are able to treat the Covered Individual, and that the Covered Individual may elect to be referred to one of the PPO providers listed; and

C. The Covered Individual gives informed Consent to continued treatment by the non-PPO provider, acknowledging that she or he understands that continued treatment by the non-PPO provider may result in greater cost to the Covered Individual.

(n) *"Health Care Facility" (for non-Emergency Services) shall mean each of the following:*

(1) A hospital (as defined in section 1861(e) of the Social Security Act);

(2) A hospital outpatient department;

(3) A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

(4) An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

(o) *"Qualifying Payment Amount"* (QPA) shall mean generally the median contracted rates of the Plan or issuer for the item or service in the geographic region. This amount is subject to change.

(p) *"Continuing Care Patient"* shall mean:

a Covered Individual who is: (1) undergoing a course of treatment for a Serious and Complex Condition, (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill

and receiving treatment for the illness; or (5) undergoing a course of institutional or inpatient care from the provider or facility.

(q) *"Serious and Complex Condition"* shall mean one of the following:

(1) In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(2) In the case of a chronic illness or condition, a condition that is the following:

(A) Life-threatening, degenerative, potentially disabling, or congenital; and

(B) Requires specialized medical care over a prolonged period of time.

(r) "*No Surprises Act*" shall mean:

Title I of Division BB of the Consolidated Appropriations Act, 2021, P.L. 116-260.

(s) "*No Surprises Services*" shall mean the following, to the extent covered under the Plan:

(1) non-PPO Emergency Services, (2) non-PPO air ambulance services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology, neonatology and diagnostics, when performed by a non-PPO provider at a participating Health Care Facility; and (4) other non-emergency services performed by a non-PPO provider at a participating Health Care Facility with respect to which the provider does not comply with federal Notice and Consent requirements.

(t) "*Notice and Consent*" or "*Consent*" with respect to services provided at a participating Health Care Facility by a non-PPO provider, means: (1) that at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the Covered Individual is provided with a written notice, as required by federal law, that the provider is a non-PPO provider with respect to the Plan, the estimated charges for the Covered Individual's treatment and any advance limitations that the Plan may put on his or her treatment, the names of any PPO providers at the facility who are able to treat the Covered Individual and that he or she may elect to be referred to one of the PPO providers listed; and (2) the Covered Individual gives informed Consent to continued treatment by the non-PPO provider, acknowledging that he or she understands that continued treatment by the non-PPO provider may result in greater cost. The Notice and Consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-PPO provider satisfied the Notice and Consent criteria.

(u) "Durable Medical Equipment" shall mean equipment and supplies which (1) are ordered by a health care provider; (2) can withstand extended and repeated use, (3) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of an illness or injury, and (4) are for outpatient use. Such term includes, but is not limited to, breast pumps, oxygen equipment and nebulizers, home infusion supplies and equipment, hospital beds, traction equipment, wheelchairs and other assistive devices, diabetic supplies and equipment, and other similar medical equipment,

except Durable Medical Equipment that is limited or excluded under Section 3(e) of Article VI.

3. ***List of Covered Medical Expenses***

(a) Hospital Expense.

(1) Board and room furnished by a Hospital while the Eligible Employee or Dependent is confined therein, but only to the extent that the applicable Daily Board and Room allowance does not exceed the highest semi-private room rate charged by the Hospital. Private room charges shall be considered a Covered Medical Expense only when medically necessary.

(2) Hospital services and supplies furnished by a Hospital in which the Eligible Employee or Dependent is confined.

(3) Outpatient hospital-type services related to surgical procedures performed in an approved ambulatory surgical center.

(b) Surgical Expense by a Licensed Qualified Provider.

(c) Services rendered by a Licensed Qualified Provider.

(d) Private Duty Nursing Service furnished in a Hospital or elsewhere by a registered graduate nurse (one entitled to use the designation "R.N.") and private duty nursing services furnished by a licensed practical nurse if an R.N. is not available; provided, however, that in any case such nurse is one who does not ordinarily reside in the home of the Eligible Employee or Dependent and is not a member of the Eligible Employee's or Dependent's immediate family (for the purpose of this coverage, *"immediate family"* consists of the Eligible Employee, Dependent, or the Eligible Employee's spouse, children, brothers, sisters or parents); and provided, further, that charges incurred for Private Duty Nursing Service furnished outside a Hospital shall be considered Covered Medical Expenses only to the extent of charges incurred during the first thirty (30) days following discharge from such Hospital within a twelve (12) month period.

(e) The following Services and Supplies:

(1) prescription drugs and medicines; and, effective July 1, 2006, certain over-the-counter medications, as determined from time to time by the Trustees, that used to require a prescription, provided such over-the-counter medication is prescribed by a Licensed Qualified Provider. The benefit payable by the Plan for such over-the-counter medications shall be 100% of such over-the-counter medication. The benefit payable by the Plan for prescription drugs and medicines other than prescribed medications that are provided over-the-counter shall be 80% of such medication.

(a) Member-Pays-the-Difference Program

Effective July 1, 2015, if an Eligible Employee or his Dependent elects to receive a brand-name drug, they will be required to pay the difference between the cost of the brand-name drug and an equivalent generic drug, in addition to the applicable generic co-insurance, unless the generic drug is found to not be therapeutically equivalent. The difference in cost between the brand name drug and the generic drug will not be included when determining the calendar year "Out-of-Pocket" Expenses as defined in Article VI, Section 7.

(b) Pharmacogenomics Prior Authorization Program

Effective July 1, 2015, certain specialty prescription drugs, as determined from time to time by the Trustees, provided prior authorization is obtained.

(c) Non-Essential Prior Authorization Program

Effective July 1, 2015, certain non-essential prescription drugs (as determined from time to time by the Trustees), provided prior authorization is obtained.

(d) Over-the-Counter Medications

Effective July 1, 2006, certain over-the-counter medications, as determined from time to time by the Trustees that previously required a prescription, provided that such over-the-counter medication is prescribed by a Licensed Qualified Provider. The benefit payable by the Plan for such over-the-counter medications shall be 100% of such covered medication.

Effective July 1, 2015, if an Eligible Employee or his Dependent elects to receive a brand-name over-the-counter medication, they will be required to pay the difference between the cost of the over-the-counter medication and an equivalent generic drug, unless the generic drug is found to not be therapeutically equivalent. The benefit payable by the Plan for such over-the-counter medications shall be 100% of the lesser of the cost of the brand-named over-the-counter-medication and the equivalent generic drug. The difference between the brand-named over-the-counter medication and the generic drug will not be included when determining the calendar year "Out-of-Pocket" Expenses as defined in Article VI, Section 7.

(2) anesthetics and the administration thereof;

(3) oxygen and the administration thereof;

(4) rental or purchase, when cost effective, of Durable Medical Equipment;

(5) blood and blood plasma, and the administration thereof;

(6) prosthetics, braces, or crutches when necessitated by an accidental bodily injury or disease for which coverage is not excluded by this Plan;

(7) x-ray examinations or laboratory tests;

(8) x-ray therapy, an radium therapy;

(9) physiotherapy and physical therapy under the supervision of a Licensed Qualified Provider, and chiropractic treatment, but not to exceed a combined maximum of 80 visits per person in a 24 month period, provided that prior authorization is obtained for any visits exceeding a combined maximum of 40 visits in a 24 month period (disregarding for purposes of the maximum any visits for physiotherapy or physical therapy treatment due to a stroke, multiple sclerosis, a condition caused by multiple sclerosis, or a radical mastectomy).

(10) speech therapy by a qualified speech-language pathologist to restore or rehabilitate any speech loss or impairment caused by injury or disease except a mental, psychoneurotic or personality disorder or by surgery for that injury or disease. In the case of congenital defect,

speech therapy expenses will be covered, provided that corrective surgery for the defect either has been performed or is not appropriate.

(11) local use of ambulance service, when medically necessary; effective January 1, 2022, local use of non-PPO air ambulance services that are medically necessary are a No Suprises Service subject to the Plan's applicable Cost Sharing.

(12) services and supplies furnished in connection with the treatment of Temporal Mandibular Joint Syndrome up to a lifetime maximum of $1,500 per Employee or Dependent.

(13) services of a licensed acupuncturist acting within the scope of his license, not to exceed a maximum of 10 visits per person per calendar year. Acupuncture treatment by a person who is a Licensed Qualified Provider within the meaning of the first sentence of the definition of that term in Section 2(d) is not counted against the 10 visit limit.

(14) gynecological examinations and related tests performed outside an MEBA diagnostic center, up to the annual per person maximum provided for in Schedule L.

(15) one baseline mammogram for women age 35 to 39 and routine mammograms for women age 40 and older performed outside an MEBA diagnostic center, up to the annual per person maximum provided for in Schedule L.

(16) immunizations for Dependent children, up to the annual per person maximum provided for in Schedule L .

(17) orthotics up to a combined maximum lifetime benefit of $500 for each Eligible Employee and all his Dependents together. The maximum benefit limit does not apply to orthotics used as braces.

(18) routine colonoscopies, once every five years (or a Cologuard colorectal cancer screening test every five years), for participants age 45 and older and their Dependents age 45 and older; and once every five years, beginning at the earlier of age 40 or 10 years before the youngest case in the first-degree relative (i.e., a parent, sibling, or child) for participants and their Dependents with a family history of colorectal cancer or adenomatous polyps in any first-degree relative before age 60 or in two or more first-degree relatives at any age (if not a hereditary syndrome).

(19) a maximum lifetime benefit of one visit for training on the use of an insulin pump when a diagnosis of diabetes is present.

(20) hospice care for participants and their eligible dependents that are terminally ill with cancer.

(21) services incurred in connection with treatment rendered to a Dependent child who is under the age of 26 at the time of a self-inflicted injury, suicide or attempted suicide, up to the annual per person maximum provided for in Schedule L.

(22) Notwithstanding the provisions of Section 4(e) (1)(B) of this Article, services related to hematopoietic cell transplants for the treatment of Crohn's disease, when provided as part of a Phase II clinical trial.

(23) one annual influenza vaccination.

(24) coverage of well-baby visits for a newborn baby while in the hospital immediately following birth through discharge of the mother from the hospital; and

(25) coverage of statutorily-required services rendered to a newborn baby while in the hospital immediately following the birth through discharge.

(26) coverage of vision therapy prescribed by and performed under the supervision of a Licensed Qualified Provider.

(27) coverage of hemoglobin A1C testing (once annually) payable at 100%, provided the Eligible Employee or Dependent has been diagnosed as diabetic and uses a Preferred Provider Organization ("PPO") provider.

(28) coverage of diabetic nephropathy screening (once annually) payable at 100%, provided the Eligible Employee or Dependent has been diagnosed as a diabetic and uses a PPO provider.

(29) coverage of diabetic retinopathy screening (once annually) payable at 100%, provided the Eligible Employee or Dependent has been diagnosed as diabetic and uses a PPO provider.

(30) coverage of total cholesterol testing payable at 100%, provided the Eligible Employee or Dependent has been diagnosed with hyperlipidemia and uses a PPO provider.

(31) coverage of spirometry testing payable at 100%, provided the Eligible Employee or Dependent has been diagnosed with chronic obstructive pulmonary disease and uses a PPO provider.

(32) coverage of the following immunizations for Eligible Employees and their Dependents age 19 and over payable at 100%: Td/Tdap, Shingles, Pneumococcal, Meningococcal, MMR, HPV, Chickenpox, and Hepatitis A and B.

(33) coverage of preventive care office visits with a PPO provider for Eligible Employees and their Dependents under age 19 payable at 100%.

(34) occupational therapy 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 set forth in Section 3 (e) (9), a maximum of 30 visits per person annually.

(35) provide medically necessary coverage for the screening, diagnosis and treatment of Autism Spectrum Disorders for Dependent children under age 7. These treatments may include necessary assessments, evaluations and testing to determine whether an individual has one or more Autism Spectrum Disorders.

(36) coverage of 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 $50,000 and are for Dependent children under age 7 necessary to develop, maintain, or restore the functioning of the Dependent child.

(37) coverage of outpatient speech therapy, occupational therapy, and physical therapy for Dependent children under age 7 who are diagnosed with Autism Spectrum Disorder when prescribed and provided by a Licensed Qualified Provider.

(38) SARs-CoV-2 and COVID-19 diagnostic testing (including in vitro diagnostic products that are (i) approved, cleared, or authorized by the U.S. Food and Drug Administration,

(ii) developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19, or other tests that the Secretary determines appropriate in guidance) to the same extent as other covered diagnostic testing but excluding over the counter tests.

(39) Coronavirus preventive items, services, or immunizations that are intended to prevent or mitigate COVID-19, and which have received an "A" or "B" rating under the recommendations of the United States Preventive Services Task Force (USPSTF), or which have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

(40) Covered Medical Services provided by a PPO provider via telephone conference, video conference, or similar technology, subject to any Plan rules and cost-sharing requirements (e.g., deductible, co-insurance, pre-authorization, etc.) that would apply to an in-person visit for the same service.

(41) Notwithstanding Section 4(e) of this Article VI, occipital nerve decompression surgery, bilateral occipital neurectomy and ablative treatments of occipital neuralgia for Eligible Employees (and their Dependents) diagnosed with non-intractable chronic migraine, up to a maximum payment of seven thousand dollars ($7,000).

(f) Special Provision for Care and Treatment of Sexually Transmitted Diseases.

If an Eligible Employee or his Dependent incurs a Covered Medical Expense in connection with the care and treatment of a sexually transmitted disease (to the extent such expense was incurred prior to March 1, 1996), a benefit shall be payable to the Eligible Employee in an amount equal to 100% of such Covered Medical Expense, subject to a lifetime maximum benefit of $10,000 per Eligible Employee or Dependent. This lifetime maximum does not apply to expenses incurred on or after March 1, 1996 in connection with the care or treatment of a sexually transmitted disease.

(g) Special Provision for Care and Treatment of Nervous and Mental Disorders.

If an Eligible Employee or his Dependent incurs a Covered Medical Expense in connection with the care and treatment of a nervous or mental disorder, a benefit shall be payable as follows:

i. Hospital Expenses up to a maximum of three (3) days per calendar year if the Eligible Employee or his Dependent is confined in a hospital. For purposes of this Paragraph, the term hospital shall include both a general hospital and a facility operated primarily for the care or treatment of nervous or mental disorder.

ii. Outpatient Expenses up to a maximum of one hundred (100) visits in each thirty-six (36) consecutive month period will be considered at 70% of Allowable charges.

(h) Special Provision for Care and Treatment of Alcoholism and Drug and Other Substance Abuse.

If an Eligible Employee or his Dependent incurs a Covered Medical Expense in connection with the care and treatment of alcoholism and/or drug or other substance abuse, a benefit shall be payable to the Eligible Employee in an amount equal to 100% of such Covered Medical Expense, up to the annual per person maximum provided for in Schedule L.

(i) Prescription Drug Program Limitation on Quantity

The maximum quantity of prescription drugs that will be considered when purchased at participating retail pharmacies is 180 days of maintenance drugs and 34 days of acute medications for Eligible

Employees. With respect to Dependents of Eligible Employees, Pensioners and Dependents of Pensioners, the maximum quantity for all drugs is 34 days.

(j) Bariatric Surgery

If an Eligible Employee incurs Covered Medical Expenses in connection with an FDA approved bariatric procedure for the treatment of obesity, such charges shall be payable in accordance with the Plan's provisions for the payment of hospital, surgical, and medical benefits, subject to the satisfaction of the following criteria: the Eligible Employee must (i) be 18 years old or older; (ii) complete a psychological examination to determine readiness and fitness for surgery and necessary postoperative lifestyle changes, (iii) have a body mass index (BMI) of 40 or BMI equal to or greater than 35 in combination with one or more of the following co-morbid conditions: hypertension, a cardiopulmonary condition, sleep apnea, diabetes mellitus, or any life threatening or serious medical condition that weight has induced; (iv) complete a structured diet program in the two-year period that immediately precedes the request for the bariatric procedure by participation in either (x) one structured diet program for six consecutive months or (y) two structured diet programs for three consecutive months; and (v) the Covered Medical Expenses must be incurred through a Preferred Provider Organization. Coverage for FDA approved bariatric procedures is not available to Dependents of Eligible Employees or to Pensioners or Dependents of Pensioners.

(k) Gene Therapy

If an Eligible Employee or the Dependent of an Eligible Employee incurs Covered Medical Expenses in connection with Gene Therapy, such charges will be payable in accordance with the Plan's provision for the payment of hospital, surgical, and medical benefits, provided the Gene Therapy is approved by the Food and Drug Administration ("FDA"). Coverage for FDA approved Gene Therapy for Medicare eligible retirees is limited to gene therapy drugs that are approved by Medicare. Non-Medicare approved gene therapy for Medicare eligible retirees is excluded from coverage.

(l) Nutritional Counseling

If an Eligible Employee or Dependent who is at risk due to nutritional history, current dietary intake, medication use, or chronic illness or condition incurs Covered Medical Expenses in connection with professional nutritional counseling, such charges will be payable in accordance with the Plan's provisions for the payment of hospital, surgical, and medical benefits, subject to the satisfaction of the following criteria:

i. The service is provided by an eligible practitioner of nutritional counseling, functioning within his or her legal scope of practice, including

   a. Medical Doctor (M.D.)
   b. Doctor of Osteopathy (D.O.)
   c. Registered dietitian or nutritionist licensed by the State Board of Dietetic Practice of that practioner's location of practice
   d. Certified Diabetes Educator

   Nutritional counseling benefits are not provided for commercial weight loss or obesity programs, including but not limited to Diet Center®, Jenny Craig®, NutriSystem®, WeightWatchers®, or Physicians WEIGHT LOSS Centers®.

ii. Nutritional counseling beyond twelve (12) visits per condition per year is subject to medical review to determine medical necessity. If requested, documentation must

demonstrate, through a care plan and progress notes, patient progress and why additional visits are required.

(m) Gender Reassignment

If an Eligible Employee or Dependent incurs Covered Medical Expenses in connection with gender reassignment surgery, such charges shall be payable in accordance with the Plan's provisions for the payment of hospital, surgical, and medical benefits, provided the Eligible Employee or Dependent satisfies all the CareFirst eligibility guidelines established for such surgery.

(n) No Surprises Services

Effective January 1, 2022, charges for No Suprises Services are covered as required by the No Suprises Act, and subject to applicable Cost Sharing. In addition, if a Covered Individual receives No Surprise Services from a non-PPO provider that the Covered Individual thought was a PPO provider, based on inaccurate information in a current provider directory, then the No Suprises Services provided by that non-PPO provider will be covered as if the provider was a PPO provider.

(o) Emergency Services

Emergency Services are covered without the need for prior authorization.

(p) Blood Work Expenses Associated with Annual Diagnostic Examinations.

Blood work associated with an annual diagnostic examination performed at a location other than a MEBA Diagnostic Center or Designated Alternate Clinic as permitted under Article XIV, Section 1, to the extent such bloodwork is part of an annual diagnostic examination performed at a MEBA Diagnostic Center or Designated Alternate Clinic, including: bilirubin (direct), gamma glutamyl transferase, hemoglobin A1C, TSH, uric acid, urinalysis (complete), CBC (includes differential and platelets), iron (total and total iron binding capacity), lipid panel, standard (profile), comprehensive metabolic panel, RPR (diagnosis, with reflect to titer and confirmatory testing). In addition, for women age 45 and over: HS-CRP, and for men over age 45: HS-CRP, and PSA (total).

4. **Exclusions**

Except to the extent otherwise required by law, the term Covered Medical Expense shall not include expenses for:

(a) General health examinations and routine immunizations, except as provided in Section 3(e), Article I, Section 6, and Article XIV.

(b) charges incurred in connection with an injury or disease arising out of or in the course of covered employment.

(c) charges incurred in connection with (1) injury arising out of, or in the course of any employment for wage or profit, or (2) disease covered, with respect to such employment, by any workmen's compensation law, occupational disease law or similar legislation;

(d) the portion of any charge for any service or supply in excess of the Allowable charge as determined by the Trustees;

(e) (1) any treatment, medical device or drug that is either not "medically necessary" or that is "experimental, educational or investigative".

(A) A treatment, medical device or drug is not considered medically necessary if the Trustees determine, after considering any information submitted by the claimant and any other information they deem appropriate, that it is (i) not provided for the diagnosis or direct treatment of an injury or illness; (ii) not appropriate and consistent with the symptoms and diagnosis of the patient's injury or illness; or (iii) not provided in accord with commonly and customarily recognized medical practice on a national basis.

(B) A treatment, medical device or drug is considered experimental, educational or investigative if (i) the Trustees determine, after considering any information submitted by the claimant and any other information they deem appropriate, that it is experimental, educational or investigative; (ii) it is labeled as being for experimental, educational or investigative purposes (or words to that effect); (iii) the provider describes it in a patient informed consent document or in any other manner as being experimental, educational or investigative in nature (or words to that effect); or (iv) it cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and it has not been so approved for marketing at the time it is furnished.

Notwithstanding the preceding, to the extent needed to satisfy PHSA Section 2709, this Section 4(e)(1)(A) and (B) shall not deny an Eligible Employee or Dependent participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in such an approved clinical trial.

(2) any transplants of any organ or body part, other than transplants of corneas, kidneys, skin, bone marrow, blood and liver.

(f) any services not specifically included in the List of Covered Medical Expenses;

(g) except as provided in Articles XI and XII, eye examinations, or the filling or cost of eye glasses or hearing aid, except when necessitated by injury to the natural eye or ear as a result of an accidental bodily injury;

(h) orthodontia or other dental work or treatment (other than for dentinogenesis imperfecta), except when necessitated by an accidental bodily injury to the natural teeth or when a Dependent of eight years or younger must undergo dental procedures that cannot be performed safely in a dental office setting;

(i) charges incurred in connection with cosmetic surgery or treatment of any kind, except when necessitated by an accidental bodily injury, and drugs used for cosmetic purposes;

(j) charges relating to any:

(1) non-emergency surgery performed in an outpatient hospital or ambulatory surgical center setting when the Plan has not precertified such surgery is necessary, is the most cost effective method of providing treatment, and meets such other reasonable criteria as may be established by the Trustees; or

(2) varicose vein surgery or chemodenervation treatment using Botulinum Toxin or similar treatment performed in any setting when such the Plan has not precertified surgery and

treatment is necessary, is the most cost effective method of providing treatment, and meets such other reasonable criteria as may be established by the Trustees.

(k) hospital board and room, or charges for any services and supplies in connection with hospital confinement:

(1) if the confinement is a non-emergency hospital confinement and the Plan has not certified in advance that such confinement is necessary, is the most cost effective method of providing treatment, and meets such other reasonable criteria as may be established by the Trustees, and/or

(2) if the length of any one continuous period of confinement exceeds a term which has not been certified in advance by the Plan as appropriate, and/or

(3) if the charges for any one continuous period of confinement exceed $50,000.00 and additional coverage has not been certified in advance by the Plan as appropriate;

(l) with respect to Pensioners and their Dependents, the care or treatment of nervous or mental disorders, alcoholism, or drug or other substance abuse, not specifically covered under Sections 2(a)(2) and 2(b)(2) of Article VIII;

(m) with respect to Pensioners and their Dependents, the care or treatment of sexually transmitted diseases to the extent such expenses are incurred prior to March 1, 1996.

(n) transportation or other travel, other than local use of ambulance service;

(o) any item described in the provision entitled "Covered Medical Expense" that is received:

(1) in connection with pregnancy or pregnancy-related disabilities of a Dependent other than a Dependent spouse of the Eligible Employee;

(2) as a result of an injury or disease resulting from war or any act of war, whether declared or undeclared, which war or act of war occurs while the Eligible Employee or Dependent is covered;

(3) in a United States Government Hospital, Marine or Veterans' Hospital, or elsewhere where care is provided at Federal Government expense, unless required by law;

(4) as a result of self-inflicted injury, suicide or attempted suicide by Eligible Employees, Dependent spouses and Dependent children age 26 or older, unless incurred as the result of a mental illness such that application of this exclusion would violate ERISA Section 702;

(5) as a result of an injury or illness that is caused, directly or indirectly, by participation in a riot or the commission of a felony, except that injuries or illnesses incurred as a result of being a victim of domestic violence shall not be excluded.

(p) care, treatment or maintenance received after the sick or injured Eligible Employee or Dependent has been cured, or after the date the illness or incapacity has been declared of a permanent nature and/or not responsive to further treatment;

(q) charges incurred in connection with: (i) in vitro fertilization, (ii) artificial insemination, (iii) reverse tubal ligation, (iv) vasovasostomy , (v) surgical procedures performed for the treatment of obesity

(except as provided in Section 3(j)), and (vi) the reversal of any surgical procedures performed for the treatment of obesity (including those described in Section 3(j)).

(r) orthotics, except when used as braces or as provided in Section 3(e)(17).

(s) oral medications for impotence in excess of six (6) doses per month.

(t) unauthorized prescription refills and lost prescriptions.

(u) compound medications (as defined by the U.S. Food and Drug Administration (FDA)), unless the use of such medications is determined to be medically necessary. The FDA defines a compound medication as one that requires a licensed pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription.

5. The benefits provided under this Article VI shall be payable in connection with Covered Medical Expenses incurred as a result of pregnancy or pregnancy-related disabilities of an Eligible Employee or an Eligible Employee's dependent spouse, provided, such expenses were incurred during a period of eligibility of the Eligible Employee, or the pregnancy commenced during a period of eligibility of the Eligible Employee.

6. If any Eligible Employee or Dependent is wholly disabled as a result of bodily injury or disease as hereinbefore described on the date the eligibility of the Eligible Employee terminates and such Eligible Employee or Dependent incurs Covered Medical Expenses within three (3) months of such termination and during the continuance of the disability, the benefit herein payable shall be payable if it would otherwise have been payable during the eligibility of the Eligible Employee.

7. Catastrophic Protection Rider:

(a) Catastrophic Protection Rider – Medical Expenses. If an Eligible Employee and/or Eligible Dependent incurs "Out-of-Pocket" Expenses in excess of $3,500, within a calendar year, exclusive of prescription drug expenses, Covered Medical Expenses (other than prescription drug expenses) incurred by such Employee and Dependent for the remainder of the calendar year shall be payable at the rate of 100%.

(b) *Catastrophic Protection Rider – Prescription Drug Expenses.* If an Eligible Employee and/or Eligible Dependent incurs "Out-of-Pocket" prescription drug expenses in excess of $1,500 within a calendar year, prescription drug expenses incurred by such Employee and Dependent for the remainder of the calendar year shall be payable at the rate of 100%.

For purposes of this coverage, "Out-of-Pocket" Expenses shall consist of the co-insurance percentage set forth in Schedule F, the Annual Deductible Amount set forth in Schedule G, any applicable Co-Pays, and expenses exceeding the maximum three (3) days per calendar year benefit when confined in a hospital as defined in Article VI, Section 3(g) (i). "Out-of-Pocket" Expenses do not include any charges in excess of a specified dollar limit for a benefit.

8. If an Eligible Employee and/or Eligible Dependent incurs "Out-of-Pocket" Expenses in excess of $5,000 within a calendar year, Covered Medical Expenses incurred by such Employee and Dependent for the remainder of the calendar year shall be payable at the rate of 100%. For purposes of this coverage, "Out-of-Pocket" Expenses shall consist of the co-insurance percentage set forth in Schedule F, the Annual Deductible Amount set forth in Schedule G, any applicable Co-Pays, and expenses exceeding the maximum three (3) days per calendar year benefit when confined in a hospital as defined in Article VI, Section 3(g)(i). "Out-of-Pocket" Expenses do not include any charges in excess of a specified dollar limit for a benefit.

9. Preferred Provider Organization.

(a) The Plan will contract for an optional form of coverage with a Preferred Provider Organization ("PPO") through which the Plan will be billed at reduced rates for certain charges received from participating Health Care Facilities and physicians. Effective January 1, 2006: a) All PPO co-pays shall be $20; b) When participating PPO providers are used, the Plan's payment will be 90% for hospital charges and 80% for medical charges, after applicable co-pays, except as provided under Article VI, Section 3(e) (14), (15), (16), and (17) and (28) – (34); and Article VI, Sections 3 (g) (ii) and (h). Effective October 25, 2007, even when a non-PPO provider is used, the Plan's payment will be 80% of Allowable medical charges where a good faith effort is made by the Eligible Employee or Dependent to use a PPO provider.

(b) Continuity of Coverage. Effective January 1, 2022, if a Covered Individual is a Continuing Care Patient and the PPO terminates its contract with a PPO provider or participating Health Care Facility that is treating that Covered Individual, the Plan will do the following:

(1) Notify the Covered Individual in a timely manner of the termination of his or her provider's facility's contract and inform the Covered Individual of their right to elect continued transitional care from that provider or facility; and

(2) If the Covered Individual elects, allow ninety (90) days of continued coverage and the determination of Cost Sharing for such continuing care services as if that provider or facility continued to be a PPO provider or participating Health Care Facility, to allow for a transition of care to a PPO provider.

10. Active Participants choosing to convert overtime under the MEBA Vacation Plan will be required to pay a contribution to the Plan equal to 6% of the gross amount of the overtime converted. Such contributions will be required on converted overtime earned on voyages commencing on or after January 1, 2006. Effective September 1, 2008, active Participants choosing to convert overtime under the MEBA Vacation Plan will no longer be required to pay a contribution to the Plan equal to 6% of the gross amount of the overtime converted.

11. Effective July 1, 2006, Active Participants will be required to pay a contribution to the Plan equal to 1% of their gross W-2 reportable wages earned while working in covered employment and of all vacation earned while working in covered employment on and after July 1, 2006. Effective July 1, 2010, Active Participants will NO LONGER be required to pay a contribution to the Plan equal to 1% of their gross W-2 reportable wages earned while working in covered employment and of all vacation earned while working in covered employment on and after July 1, 2010.

ARTICLE VI-A

ARTICLE VI-A PRE-EMPLOYMENT DRUG TEST BENEFIT

Pre-Employment Drug Test Benefit

An Eligible Employee may receive coverage of a Pre-Employment Drug Test as needed, but no more frequently than once every six (6) months, provided the Eligible Employee has worked:

(a) in covered employment for at least 60 days in the six-month period immediately preceding the Pre-Employment Drug Test, and

(b) for an Employer (or Employers) that is subject to the U.S. Department of Transportation's drug testing regulations as governed by 49 C.F.R. Part 40 and administered by the Office of Drug and Alcohol Policy and Compliance (defined in 49 C.F.R. §40.3).

A "new entrant" (as defined in Article I) will become eligible for a Pre-Employment Drug Test after completing 30 days of covered employment within any period of six consecutive calendar months.

"New entrants" and Pensioners who return to work with the permission of the Trustees must pay a fee (the amount of which the Trustees will determine in their discretion) in order to receive a Pre-Employment Drug Test.

ARTICLE VII

ALTERNATE MEDICAL PLANS

1. ***Election between Alternate Medical Plan and MEBA Medical and Benefits Plan.***

Eligible Employees who reside in certain geographic areas in the states of California, Oregon, Washington and Hawaii may elect coverage for themselves and their Dependents under contracts with certain Alternate Medical Plans, that are approved by the Trustees, in lieu of coverage provided under Article VI or any other Article of this Plan providing benefits for which the Eligible Employee or Dependent is also eligible under such Alternate Medical Plan. Once the initial election has been made, it shall be binding for a twelve (12) month period from the effective date of the election; provided, however, that a change of residence to a geographic area outside of that which is serviced by the Alternate Medical Plan in which the Eligible Employee is enrolled will terminate such enrollment. In order to re-establish coverage under this Plan, notification of the change of residence must be made by the Eligible Employee in writing to the Plan Office. After the initial twelve (12) month period, the Eligible Employee may elect to discontinue coverage under the Alternate Medical Plan. Notification of such election must be made by the Eligible Employee in writing to the Plan Office and will be effective at the end of the month in which the notification is received by the Plan Office.

2. ***Payments to Alternate Medical Plans – Restriction on Double Coverage.***

The premiums payable on behalf of Eligible Employees who elect coverage under an Alternate Medical Plan shall be paid by this Plan during the period of such coverage. In the event of such election, an Eligible Employee shall not be entitled to coverage under the provisions of Article VI or any other Article of the Plan providing benefits for which the Eligible Employee or Dependent is also eligible under the Alternate Medical Plan for the period the election remains effective.

3. ***Termination Under Alternate Medical Plan.***

The Plan will cease making premium payments on behalf of an Employee participating in an Alternate Medical Plan whose eligibility terminates under Article I. In the event of such termination, the Employee will not be entitled to coverage under either the Alternate Plan or this Plan until eligibility is re-established. An Employee who re-establishes eligibility may request re-enrollment in an Alternate Medical Plan.

ARTICLE VIII

BENEFITS FOR PENSIONERS

In accordance with Article XIX of the Plan, the Trustees have complete discretion to amend, modify, or terminate the Plan at any time and from time to time. The authority of the Trustees to amend, modify, or terminate the Plan applies to benefits for Pensioners and their Dependents as well as active Eligible Employees and their Dependents. Accordingly, no benefits provided to Eligible Employees (or their Dependents or beneficiaries) or Pensioners (or their Dependents or beneficiaries) under this Plan are (or should be considered to be) "vested".

1. ***Life Benefit***

Upon qualification for a pension from the MEBA Pension Trust, until his death, and during the period he continues to be entitled to payment of such pension, a Pensioner shall be eligible for a Life Benefit. Upon receipt of due proof of the Pensioner's death, the Trustees shall pay to his beneficiary the amount of the benefit in force in accordance with Schedule K hereof. This benefit shall not be payable to any Pensioner entitled to a life benefit under any policy previously provided by the Trustees.

2. ***Medical Expense Benefits***

The benefits available under this Section 2 of Article VIII are only available if a Participant waives coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA coverage") or elects COBRA coverage and complies with the requirements of paragraph (e)(5) of this Section with respect to such COBRA continuation coverage. Notwithstanding anything in this Section 2 to the contrary, No Suprises Services received by a Pensioner or their Dependent(s) will be covered subject to the Plan's applicable Cost Sharing only to the extent otherwise covered for Pensioners and their Dependents or as may be required by the No Suprises Act.

(a) Benefits available to Pensioners (and their Dependents) who retire with 15 or more years (10 or more years in the case of a Pensioner receiving a disability pension), but fewer than 20 years of pension credit (exclusive of credit for "Prior Maritime Employment" pursuant to Section 3.04 of the MEBA Pension Trust Regulations). Pension credit earned in covered employment under a collective bargaining agreement between an Employer and the Radio-Electronics Officers Union (the "ROU") or as an employee of the ROU or the ROU benefit plans, shall be taken into account only for determining if a Pensioner has 15 or more (or 10 or more) years of pension credit, and shall not be taken into account for determining if a Pensioner has fewer than 20 years of pension credit.

Upon qualification for a pension from the MEBA Pension Trust, until his death and during the period he continues to be entitled to such pension, a Pensioner with 15 or more years (10 or more years in the case of a Pensioner receiving a disability pension) but fewer than 20 years of pension credit (exclusive of credit for "Prior Maritime Employment" pursuant to Section 3.04 of the MEBA Pension Trust Regulations), subject to Section 2(e) of this Article VIII shall be eligible for the following benefits on a contributory basis to be paid by such Pensioner for the period described in subparagraph (3) of the Section 2(e), in the amounts determined pursuant to subparagraph (3) of Section 2(e):

(1) If a Pensioner or his Dependent incurs a Covered Medical Expense, as defined in Article VI, except for the benefits provided in Sections 3(e)(14), (15), (17), (24) and (28) - (34), and Sections 3(f), (g) and (h) of Article VI and Section 2(a)(2)(ii) of this Article VIII, as

a result of accidental bodily injury or disease, a benefit shall be payable to the Pensioner in an amount equal to 60% of the medical benefits similar to those provided under the Federal Medicare Program on behalf of himself and his Dependent spouse, provided the individual incurring such medical expenses is not eligible to receive benefits under the Federal Medicare Program. All medical benefits provided hereunder are subject to an Annual Deductible as set forth in Schedule J. The applicable Deductible Amount may be satisfied by the Pensioner and his Dependent(s) only by incurring, within the calendar year, Covered Medical Expenses of the kind or kinds which are subject to said Deductible Amount, in an amount equal to said Deductible Amount. Notwithstanding the foregoing, a Pensioner or Dependent who is otherwise covered under this Section 2(a) of Article VIII shall not be covered with respect to prescription drug and over-the-counter medication benefits. Except as otherwise noted, the benefits payable hereunder shall be subject to the provisions of Article VI. The benefits set forth in Sections 3(e)(1), (13) and (16) and Sections 3(g), (h) and (j) of Article VI are not provided. Notwithstanding the preceding sentence, the benefits set forth in Sections 3(e) (14),(15), and (28) – (34) of Article VI are provided for non-Medicare Eligible Pensioners and their Eligible Dependents and shall be payable at 100%.

(2) Special Provision for Care and Treatment of Nervous and Mental Disorders, Alcoholism, and Drug or Other Substance Abuse.

Only the following charges shall be considered Covered Medical Expenses in connection with the care and treatment of nervous and mental disorders, alcoholism, and drug or other substance abuse.

(i) Hospital Expenses up to a maximum of twenty-one (21) days in a calendar year if the Pensioner or his Dependent is confined in a hospital, up to three days of which may be in a section of a hospital, or hospital facility operated primarily for the care and treatment of nervous and mental disorders, alcoholism, or drug or other substance abuse. With regard to the remaining eighteen (18) days, charges shall be considered Covered Medical Expenses only when confinement is in a general hospital, except that; charges shall not be considered Covered Medical Expenses if the Pensioner or his Dependent is confined in a hospital, section of a hospital, or hospital facility operated primarily for the care or treatment of nervous and mental disorders, alcoholism, or drug or other substance abuse.

(ii) Outpatient expenses up to a maximum of one-hundred (100)visits in each thirty-six (36) consecutive month period will be considered at 50% of Allowable charges. Outpatient expenses for Pensioners will be treated as a separate benefit of 100 visits that begins on the Pensioner's Effective Date of Pension (as defined in the MEBA Pension Trust Regulations) and does not include any visits in the months prior to the Pensioner's Effective Date of Pension that may have been made while eligible as an Active Participant. Charges made by providers of services for the care or treatment of alcoholism or drug or other substance abuse (except as provided in subsection (1) above) shall not be considered Covered Medical Expenses.

(3) Benefits shall be provided as set forth in Section 2(a) of this Article VIII on behalf of a Dependent child as defined in Article XVIII, Section 1 of the Plan. Such benefits, however, shall not be provided on behalf of a Dependent child defined in Article XVIII, Section 1(c), (d) or (e) if such child is eligible for coverage under the Federal Medicare Program. Pensioners must elect to add any newly acquired dependent children within 30 calendar days of the event giving rise to the dependent's eligibility (birth, adoption, etc.) or the dependent shall not be eligible for the Plan.

(4) Benefits as set forth in Schedule H hereof for the Pensioner and/or each of his Dependents who are eligible to receive benefits under the Federal Medicare Program.

(b) Benefits available to Pensioners (and their Dependents) who retire with 20 or more years of pension credit (exclusive of credit for "Prior Maritime Employment" pursuant to Section 3.04 of the MEBA Pension Trust Regulations). Pension credit earned in covered employment under a collective bargaining agreement between an Employer and the ROU or as an employee of the ROU or the ROU benefit plans, shall not be taken into account for determining if a Pensioner has 20 or more years of pension credit.

Upon qualification for a pension from the MEBA Pension Trust, until his death and during the period he continues to be entitled to such pension, a Pensioner with 20 or more years of pension credit (exclusive of credit for "Prior Maritime Employment" pursuant to Section 3.04 of the MEBA Pension Trust Regulations, subject to Section 2(e) of this Article VIII shall be eligible for the following benefits on a contributory basis to be paid by such Pensioner for the period described in subparagraph (3) of Section 2(e), in the amounts determined pursuant to subparagraph (3) of Section 2(e).

(1) If a Pensioner or his Dependent incurs a Covered Medical Expense, as defined in Article VI, except for the benefits provided in Sections 3(e)(1), (14), (15), (17), (24) and (28) - (34), and Sections 3(f), (g) and (h) of Article VI and Section 2(b)(2)(ii) of this Article VIII, as a result of accidental bodily injury or disease, a benefit shall be payable to the Pensioner in the amount equal to 60% of such expense subject to an Annual Deductible in accordance with Schedule J hereof. All medical benefits provided hereunder (other than prescription drug and over-the-counter medication benefits) are subject to an Annual Deductible as set forth in Schedule J. The applicable Deductible Amount may be satisfied by the Pensioner and his Dependent(s) only by incurring, within the calendar year, Covered Medical Expenses of the kind or kinds which are subject to said Deductible Amount, in an amount equal to said Deductible Amount. Except as otherwise noted, the benefits payable hereunder shall be subject to the provisions of Article VI. Pensioners who qualify for benefits under this subsection (b) who reside in the geographic areas referred to in Section 1 of Article VII may elect to be covered under any of the Alternate Medical Plans referred to in Article VII in lieu of the coverage under this Article VIII. In the event such an election is made, the provisions of Article VII shall apply to the Pensioner and his Dependents. No Pensioner or his Dependents electing such coverage under an Alternate Medical Plan will be entitled to Diagnostic Center benefits as provided under Article XIV of these Regulations. The benefits set forth in Sections 3(e)(13) and (16) and Sections 3(g), (h) and (j) of Article VI are not provided. Notwithstanding the preceding sentence, the benefits set forth in Sections 3(e)(14),(15) and (28) – (34) of Article VI are provided for non-Medicare Eligible Pensioners and their Eligible Dependents and shall be payable at 100%.

(2) Special Provision for Care and Treatment of Nervous and Mental Disorders, Alcoholism, and Drug or Other Substance Abuse.

Only the following charges shall be considered Covered Medical Expenses in connection with the care and treatment of nervous and mental disorders, alcoholism, and drug or other substance abuse.

(i) Hospital Expenses up to a maximum of twenty-one (21) days in a calendar year if the Pensioner or his Dependent is confined in a hospital, up to three days of which may be in a section of a hospital, or hospital facility operated primarily for the

care and treatment of nervous and mental disorders, alcoholism, or drug or other substance abuse. With regard to the remaining eighteen (18) days, charges shall be considered Covered Medical Expenses only when confinement is in a general hospital, except that; charges shall not be considered Covered Medical Expenses if the Pensioner or his Dependent is confined in a hospital, section of a hospital, or hospital facility operated primarily for the care or treatment of nervous and mental disorders, alcoholism, or drug or other substance abuse.

(ii) Outpatient expenses up to a maximum of one-hundred (100) visits in each thirty-six (36) consecutive month period will be considered at 50% of Allowable charges. Outpatient expenses for Pensioners will be treated as a separate benefit of 100 visits that begins on the Pensioner's Effective Date of Pension (as defined in the MEBA Pension Trust Regulations) and does not include any visits in the months prior to the Pensioner's Effective Date of Pension that may have been made while eligible as an Active Participant. Charges made by providers of services for the care or treatment of alcoholism or drug or other substance abuse (except as provided in subsection (1) above) shall not be considered Covered Medical Expenses.

(3) For all purposes of this Article VIII; the benefits set forth in Section 3(e)(13) and (16) and Section 3(j) of Article VI are not provided; and

(4) Benefits shall be provided as set forth in Section 2(b) of this Article VIII on behalf of a Dependent child, as defined in Article XVIII, Section 1 of the Plan. Such benefits however, shall not be provided on behalf of a Dependent child defined in Article XVIII, Section 1 (c), (d) or (e) if such child is eligible for coverage under Federal Medicare Program. Pensioners must elect to add any newly acquired dependent children within 30 calendar days of the event giving rise to the dependent's eligibility (birth, adoption, etc.) or the dependent shall not be eligible for the Plan.

(5) Benefits as set forth in Schedule H hereof for the Pensioner and/or each of his Dependents who are eligible to receive benefits under the Federal Medicare Program.

(6) If the Pensioner, spouse or child is eligible for coverage under the Federal Medicare Program, any benefits provided under subparagraphs (1), (2) and (3) of this Section 2(b) shall be paid as a supplement, only, to the benefits payable under the Federal Medicare Program whether or not such benefits are actually received. Further, such benefits as provided under subparagraphs (1), (2) and (3) of this Section 2(b) shall be payable to the extent that the total benefits payable by this Plan and by the Federal Medicare Program shall not exceed the limitations and maximums as set forth in this Article VIII and in Section 1(a) and (c) and Sections (2) through (7) of Article VI hereof. A Pensioner or Dependent who would have been eligible for coverage under the Federal Medicare Program except for the fact that he resides outside of the United Stated shall be deemed, for the purpose of this Section, to be eligible for benefits under the Federal Medicare Program.

(c) ***Catastrophic Protection Rider:***

(a) *Catastrophic Protection Rider – Medical Expenses.*

If a Pensioner and/or Dependent of a Pensioner who is eligible for coverage under this Article VIII incurs "Out-of-Pocket" Expenses in excess of *$3,500*, within a calendar year, exclusive of prescription drug expenses, Covered Medical Expenses (other than

prescription drug expenses) incurred by such Employee and Dependent for the remainder of the calendar year shall be payable at the rate of 100%.

(b) *Catastrophic Protection Rider – Prescription Drug Expenses.*

If a Pensioner and/or Dependent of a Pensioner who is eligible for coverage under this Article VIII incurs "Out-of-Pocket" prescription drug expenses in excess of $1,500 within a calendar year, prescription drug expenses incurred by such Employee and Dependent for the remainder of the calendar year shall be payable at the rate of 100%.

For purposes of this coverage, "Out-of-Pocket" Expenses shall consist of the co-insurance percentage set forth in Schedule I, the Annual Deductible Amount set forth in Schedule J and any applicable Co-Pays.

(d) ***Preferred Provider Organization.***

(1) The Plan will contract for an optional form of coverage with a Preferred Provider Organization ("PPO") through which the Plan will be billed at reduced rates for certain charges received from participating Health Care Facilities and physicians. This coverage will not be available to Pensioners and their Dependents who are eligible for coverage under the Federal Medicare Program. Effective January 1, 2006, eligible Pensioners with 20 or more years of pension credit and their Dependents who select health care providers participating in the PPO shall receive benefits as follows: a) All PPO co-pays shall be increased from $10 to $20; b) The Plan's payment will be 90% for hospital charges and 80% for medical charges, after applicable co-pays, except as provided under Article VI, Sections 3 (e)(28) - (34) and Article VIII, Section (2) (b) (2) and (ii). Eligible Pensioners with less than 20 years of pension credit (exclusive of credit for "Prior Maritime Employment" pursuant to Section 3.04 of the MEBA Pension Trust Regulations) and their Dependents will be covered under Section 2(a)(1) of Article VIII but will be billed at reduced rates if they select health care providers participating in the PPO. Effective October 25, 2007, even when a non-PPO provider is used, the Plan's payment will be 80% of Allowable medical charges where a good faith effort is made by the Eligible Employee or Dependent to use a PPO provider.

(2) Continuity of Coverage. Effective January 1, 2022, if a Covered Individual is a Continuing Care Patient and the PPO terminates its contract with a PPO provider or participating Health Care Facility that is treating that Covered Individual, the Plan will do the following:

(1) Notify the Covered Individual in a timely manner of the termination of his or her provider's or facility's contract and inform the Covered Individual of their right to elect continued transitional care from that provider or facility; and

(2) If the Covered Individual elects, allow ninety (90 days of continued coverage and the determination of Cost Sharing for such continuing care services as if that provider or facility continued to be a PPO provider or PPO facility, to allow for a transition of care to a PPO provider.

(e) ***Pensioner Contributions.***

The following terms and conditions shall apply, effective January 1, 1995, to the Pensioner Contributions referred to in subsection (1) and (b) of this Section 2:

(1) For Pensioners who Retired prior to January 1, 1995 and have not terminated their participation in the Plan as of December 31, 1994 or Pensioners who Retire on or after January 1, 1995, the benefits under Article VIII shall be provided on a contributory basis to be paid by such Pensioners as set forth below. The term Pensioner shall have the meaning set forth in Article XVIII, Section 6.

(2) The Pensioner Contribution shall be as follows:

(i) *Non-Medicare Eligible Pensioner Contributions:* Non-Medicare Eligible Pensioner contribution requirements shall be 6.9% of each Pensioner's gross monthly Pension benefit, calculated as a straight life annuity, but subject to the following:

a. *Effective July 1, 2015:*

(1) for Non-Medicare Eligible Pensioners with no dependents, the minimum monthly contribution will be $345;

(2) for Non-Medicare Eligible Pensioners with dependents the minimum monthly contribution will be $575;

(3) for Non-Medicare Eligible Pensioners with dependent coverage, such dependent coverage may be dropped but may be reinstated only once; reinstatement for such dropped dependent coverage shall be conditioned upon providing the Plan with proof that other insurance coverage was in place for the dropped dependents during the entire period while not covered by the Plan. Any request for reinstatement and proof of other insurance coverage must be submitted to the Plan within 30 days of the termination of such other coverage.

b. With respect to Pensioners who received their Pension under the Lump Sum Distribution method, contributions will be determined based on the straight life annuity used to calculate the Pensioner's Lump Sum Distribution.

(ii) *Medicare Eligible Pensioner Contributions:* Effective July 1, 2015, Medicare Eligible Pensioner contribution requirements will be 6.45% of each Pensioner's gross monthly Pension benefit calculated as a straight life annuity, or $107.50, whichever is greater.

With respect to Pensioners who received their Pension under the Lump Sum Distribution method, contributions will be determined based on the straight life annuity used to calculate the Pensioner's Lump Sum Distribution.

(3) Payment of the Pensioner Contribution shall be required by the first day of each calendar month for which such contributions are required, or, in the case of Pensioners who have not directed payment of their contribution in accordance with subparagraph (4) of this Section 2, by either:

(i) the first day of each calendar quarter for which such contributions are required, or

(ii) the first day of each month if the Pensioner elects to use a direct debit program consistent with rules that the Plan Administrator may devise.

If, after notifying the Pensioner in writing of the nonreceipt of such payment, the Plan does not receive payment by the end of such calendar month or, in the case of quarterly payments, by the end of the first calendar month of the quarter, such Pensioner shall be deemed to have elected irrevocably to terminate his participation in the Plan and his entitlement to benefits under this Article VIII.

The Plan shall comply with the requirements of Treas. Reg. §§. 1.401 (a)-13(d)(1) and 1.401 (a)-13(e), with respect to the administration of any direct debit program.

(4) A Pensioner may elect to direct the Trustees to accept payment of all or part of his or her Pensioner Contribution from the Trustees of the MEBA Pension Plan and Trust pursuant to Section 1.401 (a)-13(e) of the Treasury Regulations , such election to be revocable by the Pensioner at any time. To the extent required by any applicable rules issued by the United States Department of Labor, the MEBA Medical and Benefits Plan shall reimburse the MEBA Pension Plan for the cost of providing any services to the MEBA Medical and Benefits Plan.

(5) A Pensioner eligible for continuation of coverage as an Active Employee under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA coverage"), who timely elects to receive such COBRA coverage, may elect to maintain Pensioner benefits under this Section 2 at the time the COBRA coverage ends for any reason, and only at that time and if any time remains in the COBRA coverage period, the Pensioner must waive COBRA coverage for the remaining period of COBRA coverage eligibility to receive benefits under this Section 2.

(6) Pensioners shall be permitted to elect at any time to terminate Pension benefits, such elections to be irrevocable. Upon such election, the Pensioner Contributions required under paragraph (2) of this Section 2(d) shall cease.

(7) Subject to the limitation of this subsection (e), surviving dependents who meet the requirement of Article XVIII (1)(a), (b) or (d) may elect to receive the benefits available under Article VIII (2) of these Rules and Regulations provided:

(i) they are dependents of an Eligible Employee who, at the time of his death on or after November 1, 2003, had at least 5 years of vesting credit and was actively employed; or, who retired on or after November 1, 2003 and, at the time of his death had at least 5 years of vesting credit; and

(ii) they pay the normal monthly pension contributions and optional retiree dental contributions (if applicable).

Coverage for surviving dependents under this subparagraph (7) will cease upon loss of eligibility for dependent coverage under Article XVIII or, in the case of a surviving spouse, upon spouse's attainment of age 65 and eligibility for Medicare.

(8) A Pensioner who is permitted to return to Covered Employment under Section 2.08 of the MEBA Pension Trust Regulations and for whom Employer contributions are received, may request reimbursement of Pensioner Contributions made to cover periods of active employment provided:

(i) The Pensioner has made Pensioner Contributions with respect to the periods of active employment. (Failure to do so results in termination of the Pensioner's Retiree medical coverage under Article VIII, Section 2(e) (3).)

(ii) The Pensioner returns to active employment and works at least 90 consecutive days in Covered Employment; and

(iii) The Pensioner submits an application for reimbursement of Pensioner Contributions and documentation required by the Plan Office within twelve (12) months from the last day of Covered Employment.

The above requirements having been met, monthly Pensioner Contributions made with respect to periods in excess of 89 days in Covered Employment will be reimbursed as follows: 1 day to 89 days, no reimbursement; 90 days to 119 days, reimbursement of one (1) month of Pensioner Contributions; 120 days to 149 days, reimbursement of two (2) months of Pensioner Contributions; and so forth.

(On the day the Pensioner's return to active employment ends, the Pensioner's eligibility under Article I (for active benefits) terminates, and the Pensioner reverts to coverage for Pensioner benefits under Article VIII.)

(f) For purposes of subsections (a) and (b) of this Section 2 and Section 6(a) of Article XVIII, an Eligible Employee is also deemed to have earned pension credit as follows. An Eligible Employee is deemed to have worked days in covered employment for purposes of computing pension credit under the MEBA Pension Trust for any days worked under a collective bargaining agreement for which the employer was obligated to contribute on his behalf both to this Medical Plan for full coverage and to the Money Purchase Benefit under the Pension Trust, but for which the employer was not obligated to contribute to the defined benefit portion of the Pension Trust.

(g) ***Termination of Coverage***

Coverage under this Plan shall automatically terminate on the date on which the Pensioner ceases to be eligible for benefits in accordance with any Plan Article; or

Notwithstanding the preceding sentence, coverage or benefits may continue if and to the extent provided for each benefit under an applicable insurance contract, policy, or applicable law.

If a Pensioner and/or his eligible Dependents experience an event that makes such person ineligible to continue coverage under the Plan, the Pensioner is required to notify the Plan Office in writing within 30 days of the event that impacts continuing eligibility under the Plan. Failure to report such event within 30 days may result in the Pensioner reimbursing the Plan for claims paid under the Plan after the event causing termination of coverage.

Events that must be reported to the Plan Office and may lead to ineligibility and loss of coverage include but are not limited to the following:

1) divorce;

2) legal separation;

3) eligibility for other medical coverage;

4) a stepchild or grandchild's change in marital status, change in student status, change in residency or change in custody or support;

5) a grandchild's failure to meet the grandchild eligibility requirements described in the definition of Dependent under Article XVIII;

6) a parent's failure to meet the rules established by the Trustees; and

7) a Pensioner's return to work under certain circumstances without the permission of the Trustees.

Notwithstanding the foregoing, medical benefits shall not be cancelled or discontinued with a retroactive effect with respect to a Pensioner or Dependent except in the event of fraud or intentional misrepresentation or termination for non-payment of a required premium.

3. ***Optical, Hearing Aid and Diagnostic Center Benefits.***

Upon qualification for a pension from the MEBA Pension Trust and until his death and during the period he continues to be entitled to such pension, a Pensioner and his Dependents shall be eligible for the benefits set forth in Section 2 of Article XI and Article XII and XIV of the Plan.

4. ***Continuation of Benefits.***

A Pensioner who is permitted to return to covered employment under Section 2.08 of the MEBA Pension Trust Regulations shall continue to be entitled to the benefits provided in this Article VIII until he has worked sufficient time in covered employment to become eligible for the benefits available to active Eligible Employees under other provisions of this Plan. Upon subsequent retirement, such Pensioners who were reemployed with less than 20 years of pension credit shall have the period of their reemployment added to their prior pension credit in order to determine whether they have 20 years of pension credit for purposes of their benefit entitlement under Section 2(a) or (b) of this Article VIII.

5. ***Termination of Eligibility.***

This Section 5 applies to a Pensioner who is deemed to have earned pension credit under Section 2(f), on the same terms as though the Pensioner was subject to Sections 2.07 through 2.10 of the MEBA Pension Trust.

A Pensioner who has retired in accordance with Section 1.35 of the MEBA Pension Trust Regulations may not return to covered employment or employment prohibited by the MEBA Pension Trust Regulations without the written permission of the Trustees of the Pension Trust. If a Pensioner returns to covered or prohibited employment without the written permission of the Trustees of the Pension Trust, such Pensioner shall forfeit eligibility for benefits under this Plan as follows:

(i) First Occurrence. If the Pensioner has not previously engaged in prohibited employment and, upon being notified by the Plan Administrator of his engagement in prohibited employment, the Pensioner takes immediate action to cease such prohibited employment, the Pensioner will be suspended from eligibility for benefits under this Plan for a period of eighteen (18) months. At the end of the eighteen (18) month suspension period, the Pensioner will be restored to eligibility for benefits under this Plan provided the Pensioner has continued coverage under this Plan during the entire eighteen (18) month suspension period by paying for such coverage at COBRA rates. If the Pensioner fails to take immediate action to cease such prohibited employment or fails to continue coverage under this Plan during the entire eighteen (18) month suspension period, the Pensioner shall immediately and permanently forfeit all eligibility for benefits under this Article VIII.

(ii) Second Occurrence. If a Pensioner has previously engaged in prohibited employment and again engages in prohibited employment, the Pensioner shall immediately and permanently forfeit all eligibility for benefits under this Article VIII.

In the event of the death of a Pensioner participating in the Plan under subsection 2(d) of this Article VIII, Dependent benefits under the Plan shall continue through the last day of the month following the month in which the Pensioner's death occurred.

6. ***Earnings Limit on All Benefits.***

Effective retroactive to January 1, 2003, the earnings limitation on benefits is eliminated.

7. ***Medicare Part D No-Dual Coverage Rule:*** If a Medicare-eligible Pensioner enrolls in any Part D Medicare Prescription Plan in any year, prescription coverage under the MEBA Medical Plan will terminate for that year. Subsequently, on an annual basis, should the Medicare-eligible Pensioner terminate enrollment in the non-MEBA Medical Plan Part D Medicare Prescription Plan, he will be permitted to reinstate his prescription coverage under the Medical Plan. The Pensioner's contribution obligation will remain at the then current level in all events.

8. ***Retiree Dental Benefit***.

Upon qualification for a pension from the MEBA Pension Trust and during the period the Pensioner continues to be entitled to such pension, a Pensioner and the Pensioner's Dependents shall be eligible for the benefits set forth in Article XV of the Plan, subject to the Pensioner's timely electing the dental benefits and making the required contributions as determined by the Trustees from time to time. Pensioners will have one opportunity to opt-in to receive retiree dental benefits. If a Pensioner fails to elect retiree dental benefits for themselves and their Dependents at the time he or she applies for a pension and is presented with the option, or if an existing Pensioner fails to opt-in to receive retiree dental benefits during the one-time opportunity presented to him or her, he or she shall not be eligible for the benefits set forth in Article XV of the Plan.

A Pensioner may elect to have the contributions for retiree dental benefits withheld from his or her pension benefits as provided in Section 2(e)(4).

ARTICLE IX

BENEFITS FOR ADMINISTRATIVE EMPLOYEES AND CERTAIN OTHER EMPLOYEES

The provisions of this Article IX shall be applicable to Employees of the MEBA Administrative Plan Office and certain other Employees as defined below, who are not covered under the provisions of Article I or Article X hereof.

1. ***Definitions***

For purposes of this Article IX, the term "Employees" shall mean:

(a) Each regular employee of the MEBA Administrative Plan Office who is not covered by a collective bargaining agreement and for whom contributions are made to the Plan.

(b) Clerical employees and certain non-deep sea personnel who have become entitled to certain benefits hereunder upon the individual agreement between the employees' Employer and the Union or District No. 1-Pacific Coast District, MEBA and any of its affiliates to contribute to the Plan such amounts as are necessary to provide the contractually agreed upon benefits.

2. ***Eligibility***

An Employee, as defined in Section 1(a) of this Article IX, shall become eligible for benefits hereinafter described on the date such Employee completes one month of continuous service for which contributions have been made to the Plan; provided, however, that the eligibility of an Employee who is at the time of employment eligible under Article I shall commence upon the date he commences active service.

A former Employee, as defined above, who becomes re-employed by the Administrative Plan Office shall again become eligible for benefits after completing 60 days of continuous service for which contributions have been made to the Plan.

3. ***Termination of Eligibility***

Eligibility for benefits hereunder shall cease on the last day of the month during which the Employee was last on the payroll of the Employer, except in the case of benefits provided under Articles III and IV hereof, if applicable, in which case eligibility shall cease on the last day of the month following the month during which the Employee was last on the payroll of the Employer; provided, however, that the eligibility of an Employee who is eligible under Article I shall continue for six (6) months after such Employee's last date on payroll of the Employer.

The term *"last date on payroll"* shall mean the last date for which contributions are made to the Plan on behalf of the Employee except that in the case of continued sickness, injury or official leave of absence, employment shall be deemed to continue until the last day of the third calendar month following the month during which the Employee was last on the payroll of the Employer, or until the Employee becomes employed elsewhere, whichever occurs first. The period of eligibility in the case of sickness, injury or leave of absence may be extended by the Trustees, in their sole discretion, after consideration of all the facts.

4. ***Benefits***

(a) When eligible, an Employee described in Section 1(a) of this Article IX shall be entitled to the Life Benefit and Accidental Death and Dismemberment benefits pursuant to Articles III and IV hereof and such Employee shall also be entitled, for himself and his Dependents, to the benefits provided under Articles VI, XI, XII, XIV, and XV hereof. An Employee who retires from the Administrative Plan Office under the MEBA Pension Trust shall also be eligible for benefits as a Pensioner under Article VIII.

(b) When eligible, an Employee described in Section 1(b) of this Article IX shall be entitled to those benefits which have been contractually agreed upon between the Employee's Employer and the Union or District No. 1-Pacific Coast District, MEBA and any of its affiliates and for which contributions are made to the Plan.

5. A Pensioner who is permitted to return to Covered Employment under Appendix H, Section H2.09(b)(6), of the MEBA Pension Trust Regulations and for whom Employer contributions are received, may request reimbursement of Pensioner Contributions made to cover periods of active employment provided:

(a) The Pensioner has made Pensioner Contributions with respect to the periods of active employment. (Failure to do so results in termination of the Pensioner's Retiree medical coverage under Article VIII, Section 2(e) (3).)

(b) The Pensioner returns to active employment and works at least 90 consecutive days in Covered Employment: and

(c) The Pensioner submits an application for reimbursement of Pensioner Contributions and documentation required by the Plan Office within twelve (12) months from the last day of Covered Employment.

The above requirements having been met, monthly Pensioner Contributions made with respect to periods in excess of 89 days in Covered Employment will be reimbursed as follows: 1 day to 89 days, no reimbursement; 90 days to 119 days, reimbursement of one (1) month of Pensioner Contributions; 120 days to 149 days, reimbursement of two (2) months of Pensioner Contributions; and so forth. (On the day the Pensioner's return to active employment ends, the Pensioner's eligibility under Article IX (for active benefits) terminates, and the Pensioner reverts to coverage for Pensioner benefits under Article VIII.)

ARTICLE X

BENEFITS FOR UNION EMPLOYEES

Employees of the Union and of District No. 1-Pacific Coast District, MEBA and any of its affiliates which have become parties to the Agreement and Declaration of Trust (collectively the "Union"), may become entitled to certain benefits hereunder upon the individual agreement of the Union and District No. 1-Pacific Coast District, MEBA and any of its affiliates, to contribute to the Plan such amounts reasonably necessary to insure the economic feasibility of the program as may be established by the Trustees. Benefits shall be available upon the conditions set forth in this Article X.

1. ***Eligibility***

Each regular office employee of the Union shall become eligible for benefits hereinafter described on the date he completes one month of continuous service; provided, however, that the eligibility of an Employee, who is at the time of employment eligible under Article I shall commence upon the date he commences active service.

For the purpose of this Article, the term *"regular office employee"* shall include each member in good standing of the Union (including officials and representative) employed by the Union which have become parties to the Agreement and Declaration of Trust.

2. ***Termination of Eligibility***

The eligibility of a regular office employee of the Union for benefits under this Article shall cease on the last day of the month during which the Employee was last on the payroll of the Union, except in the case of benefits provided under Articles III and IV hereof, if applicable, in which case eligibility shall cease on the last day of the month following the month during which the Employee was last on the payroll of the Union; provided that the eligibility of an Employee who is eligible under Article I shall continue for six (6) months after such Employee's last date on payroll. The term *"last date on payroll"* shall mean the last date for which contributions are made by the Union to the Plan on behalf of the Employee, except that in the case of continued sickness, injury or official leave of absence, employment shall be deemed to continue until the last day of the third calendar month following the month in which the Employee was last on the Union's payroll or until the Employee commences employment elsewhere, whichever occurs first. The period of eligibility in the case of sickness, injury or leave of absence may be extended by the Trustees, in their discretion, after consideration of all the facts.

3. ***Benefits***

When eligible, each regular office employee of the Union shall be entitled to the Life Benefit and Accidental Death and Dismemberment benefits pursuant to Articles III and IV hereof and such Employee shall also be entitled, for himself and his Dependents, to the benefits provided under Article VI, XI, XII, XIV and XV hereof. An employee of the Union who retires under the MEBA Pension Trust shall also be eligible for benefits as a Pensioner under Article VIII.

ARTICLE XI

OPTICAL BENEFIT

1. Eligible Employees

   (a) Eligible Employees, Dependent spouses and Dependent children age 19 years or older, shall be entitled to optical benefits in an amount equal to the charges incurred for eye care, up to a maximum of $180.00 during a calendar year and if such participant does not use all or part of the maximum benefit of $180.00 during a calendar year, the balance may be carried over for two additional calendar years, up to a maximum three-year benefit of $540.00.

   (b) Eligible Employee's Dependent children under age 19 years shall be entitled to optical benefits in an amount equal to the charges incurred for eye care limited to one exam and one pair of glasses (lenses and frames) or contact lenses per calendar year, up to the annual per person maximum provided for in Schedule L.

2. Pensioners

   (a) Pensioners, Dependent spouses and Dependent children age 19 years or older, shall be entitled to optical benefits in an amount equal to 80% of the first $120.00 of charges incurred for eye care during a calendar year and if such participant does not use all or part of the maximum benefit of 80% of $120.00 during a calendar year, the balance may be carried over for two additional calendar years, up to a maximum three-year benefit in an amount equal to 80% of $360.00.

   (b) A Pensioner's Dependent children under age 19 years shall be entitled to optical benefits in an amount of 80% of Allowable charges incurred for eye care limited to one exam and one pair of glasses (lenses and frames) or contact lenses per calendar year, up to the annual per person maximum provided for in Schedule L.

   (c) Pensioners (and their Dependent spouse and Dependent children) shall be entitled to coverage of vision therapy only to the extent such vision therapy would be a covered expense under Article VI, Section 3(e) (27).

3. Within the limitations set forth above, optical benefits shall be payable for any combination of the following services and such combination may include the rendering of any one of the following services more than once, at the same or at different times:

   Examination by an Ophthalmologist or Optometrist
   Single Vision or Bi-focal eyeglasses
   Safety Lenses
   Extra Heavy Lenses
   Contact Lenses
   Prescription Sunglasses

ARTICLE XII

HEARING AID BENEFIT

Eligible Employees (and their Dependents) and Pensioners (and their Dependents) shall be entitled to hearing aid benefits in an amount equal to 80% of the charges incurred for a hearing aid. The maximum benefit payable under this provision shall be $3,000 every three (3) calendar years.

The Plan will also pay the first $75.00 of the sum of all such charges for hearing related examinations every two (2) calendar years for Eligible Employees (and their Dependents) and Pensioners (and their Dependents).

Notwithstanding the preceding paragraph, for Dependents younger than 19 years old, the Plan will pay the first $75.00 of the sum of all charges for hearing related examinations once per calendar year.

ARTICLE XIII

INSURANCE FOR FAILURE OF WAGE PAYMENTS

Under rules and subject to conditions established by the Trustees in their sole discretion, in the event an Eligible Employee shall be unable to collect his wages (which shall be deemed to include all compensation due by reason of employment on a vessel, but shall not include any payment or penalty which is not provided for under the collective bargaining agreement) without recourse to legal, equitable or admiralty proceedings because his employer is insolvent bankrupt, or otherwise unable to pay the compensation due him, he shall be entitled to a payment from the Plan equal to the amount of his uncollected wages, taking into account any collection expenses which might be reasonably incurred.

RULES OF THE WAGE INSURANCE PROGRAM
UNDER ARTICLE XIII OF THE
MEBA MEDICAL AND BENEFITS PLAN

I. *Introduction*

This benefit has been established by the Trustees of the MEBA Medical and Benefits Plan in order that Eligible Employees shall be protected in cases of the financial inability of Employer to pay the compensation due and the only recourse of the Eligible Employee is to legal, equitable or admiralty proceedings. The benefit is intended to provide a prompt payment to an Eligible Employee of the amount which he could expect to recover in a legal, equitable or admiralty proceeding, less an amount held in escrow which on the average might be required as expenses of recovery and administration of the program. Upon completion of the procedures established by the Trustees, an Eligible Employee shall not have any responsibility to return any payment made to him, except for fraud or willful misrepresentation.

II. *Application for Benefits*

1. Application for benefits shall be made on forms provided by the Plan Office.

2. Proof of the amount due as compensation must be submitted before any payment will be made. Normally, a statement from the Master of the vessel or the Employer will be the best evidence, and failure of allotment payments must be established. The Plan Office will assist in trying to establish facts from the Employer. The information required for payment is the same type of information which would be required by a Federal Court to substantiate the amount due.

3. After completion of proof and execution of other documents, the Plan will pay to the Eligible Employee 90% of the amount of compensation ascertained to be due him. Except when procured by fraud or misrepresentation, this payment is final and not subject to any claim by the Plan. The remaining 10% of the full amount will be held in escrow subject to accounting.

4. Prior to payment the Eligible Employee shall execute an assignment, in a form acceptable to the Trustees, of all his rights with respect to the wage payments involved, including an assignment of his maritime lien therefore, and authorize the Trustees to sue for same either in his name or their names.

   The Eligible Employee shall also execute an authorization for the Plan to apply the 10% of full payment, held in escrow as above provided, for legal and administrative expenses, incurred by the Plan in connection with the administration of the Wage Insurance Program.

From time to time, the Administrator shall make an accounting of the costs of the Wage Insurance Program to all those who receive payments thereunder.

ARTICLE XIII-A

LEGAL AID REPRESENTATION IN THE UNITED STATES COAST GUARD LICENSE PROCEEDINGS

In the event an Eligible Employee receives notice or notification of an investigation, complaint or any other action instituted by the United States Coast Guard, that may adversely affect the status of such Employee's United States Coast Guard license, such Employee shall be entitled to be represented by legal counsel as a benefit hereunder. The Plan Office maintains a list of attorneys who provide Coast Guard legal aid representation service in various ports.

All Eligible Employees seeking to avail themselves of this benefit should immediately inquire of the Plan Office for the name of the attorney designated to perform the services in the area where the investigation, complaint or action against such Employee is instituted and/or pending.

If an Eligible Employee who has previously had his license revoked or suspended in an action concerning alleged drug or alcohol use receives a second such notice or notification of an investigation, complaint or any other action instituted by the United States Coast Guard concerning alleged drug or alcohol use, within five years of the first action, such Employee shall not be entitled to be represented by legal counsel as a benefit hereunder. However, if such Employee is found not guilty of the alleged second offense, or if the charge or complaint is otherwise dropped or dismissed, the Plan shall reimburse the Employee for reasonable legal costs incurred by such Employee in defending against the second charge or complaint. An employee who is ineligible for benefits under this paragraph may nonetheless contact the Plan Office for the name of an attorney in his area to represent him at his own expense.

In the event a United States Coast Guard license investigation, complaint or other action is instituted or pending against an Eligible Employee, in a geographic area that either does not have a legal aid attorney designated or that is too far away from the location of the nearest such attorney, an Eligible Employee may retain the services of another attorney at the expense of the Plan; provided, however, such Employee receives prior written approval from the Plan Administrator that it would be impracticable for one of the designated attorneys to represent such Employee.

ARTICLE XIV

ANNUAL DIAGNOSTIC EXAMINATIONS

1. Eligible Employees (and their Dependents) and Pensioners (and their Dependents) shall be entitled to diagnostic examinations available through the MEBA Diagnostic Centers or an alternate clinic designated by the Board of Trustees ("Designated Alternate Clinic") not more than once in any calendar year. Effective January 1, 2024, except as otherwise required under an applicable collective bargaining agreement, this diagnostic examination may, but need not be, performed at a location other than a MEBA Diagnostic Center or Designated Alternate Clinic. Diagnostic examinations performed at a location other than a MEBA Diagnostic Center or Designated Alternate Clinic are covered with no Cost Sharing (as defined in Article VI, Section 2(j)) for in-network providers.

2. No travel expenses will be reimbursed for travel to undergo a diagnostic examination unless it is performed at an MEBA Diagnostic Center. An Eligible Employee or Pensioner who lives in excess of 75 miles from a MEBA Diagnostic Center shall be afforded one (1) round trip per year for him and his family from his home of record to the nearest MEBA Diagnostic Center.

   (a) *Travel Agency:* The Plan will arrange with an appropriate contracted travel organization for the provision of travel services to Participants attending the MEBA Diagnostic Centers. Use of the contracted travel organization ("Travel Agency") will be mandatory to receive reimbursement of all air travel expenses. A Participant must book a return flight that is within 90 days of the date of the original flight to be eligible for reimbursement. For dependents, the return flight must be booked within 14 days of the original flight to be eligible for reimbursement. Notwithstanding the preceding sentence, the Administrator may approve reimbursement of travel expenses that a Participant incurs for which the Travel Agency is not used, provided the Administrator determines that i) extenuating circumstances exist that warrant an exception to the requirement that the Travel Agency be used, and ii) such approval will result in a cost savings to the Plan.

   (b) *Travel Policy*: Reimbursement for round-trip transportation from the participant's home of record will be made in accordance with the travel reimbursement policy adopted by the Trustees. The travel policy may, from time to time, be amended by the Trustees.

   (c) *Home of Record:* The Participant's Home of Record will be the Participant's primary residence. If a Participant's 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 will be deemed to be the airport that is closest to the Participant's Home of Record and that is included on the list, designated by the Trustees, of major airports in the Continental United States.

   (d) *Frequency of Reimbursement*: Reimbursement of round-trip transportation will be afforded to a participant or eligible dependent(s) to attend a MEBA Diagnostic Center. No more than one round-trip reimbursement will be made for any person during any calendar year. Travel paid or reimbursed by a MEBA Training Plan contributing employer for travel to the School or by the MEBA Training Plan for transportation to the School immediately before or after a MEBA Diagnostic Center exam will not be eligible for reimbursement by the MEBA Medical and Benefits Plan.

   (e) *Travel by Train or Bus*: Reimbursement for travel by train or bus shall be based on the actual fare incurred; however reimbursement will not exceed the maximum amount payable had the participant traveled by air and used the Plan's travel organization.

   (f) *Travel by Automobile*: Reimbursement for travel by automobile shall be based upon mileage, payable at a per mile rate not to exceed the IRS mileage allowance then in effect and will not exceed the maximum amount payable had the participant traveled by air and used the Plan's travel organization.

The maximum reimbursable mileage shall be computed on the basis of official automobile club maps. For automobile travel in excess of 400 miles one way, gasoline and/or hotel receipts must be presented to establish actual travel.

(g) *Payment*: Travel reimbursement will be paid upon receipt by the Plan Office of a properly completed Diagnostic Center reimbursement claim and actual travel documentation.

(h) *ROS Employment*: In the case of a participant employed as a permanent ROS employee traveling from a ROS vessel, reimbursement from the vessel will be paid in lieu of the participant's home of record.

(i) *Required Documentation*: For all travel subject to reimbursement, copies of actual travel documentation, including but not limited to, tickets, boarding passes and receipts must be presented. The Plan's Travel Agency's reports may be accepted for reimbursement in lieu of actual tickets, boarding passes, and receipts.

(j) Miscellaneous Expenses: An allowance of $20 per family shall be payable for miscellaneous expenses.

The allowance shall be increased up to a maximum of $50.00 per family for miscellaneous expenses when air travel is used, provided actual taxi/transportation receipts are presented to justify any increase.

If a participant uses a Designated Alternate Clinic and the Home of Record for such person is more than 75 miles from the Designated Alternate Clinic, an allowance of up to $50.00 per family will be available, provided transportation receipts are presented to justify the is used.

ARTICLE XV

DENTAL PROGRAM

1. The benefits under this Article are provided for Eligible Employees (and their Dependents) and Pensioners (and their Dependents) who opt-in to receive retiree dental benefits. Pensioners will have one opportunity to opt-in to receive retiree dental benefits. If a Pensioner fails to timely opt-in to receive retiree dental benefits as described in Article VIII, Section 8, he or she shall not receive benefits under this Article.

2. The benefits under this Article consist of the benefits provided under the Group Dental Contract, as in effect between the Plan and Delta Dental. Except as provided in Sections 3 and 4, no benefits are provided under this Article except for the benefits provided under the Group Dental Contract.

3. Allowable charges for orthodontia treatment are covered up to a lifetime maximum benefits of $2,250 per person. "Orthodontia" means the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids. Orthodontia must be provided by a duly licensed dentist acting within the scope of his license.

4. In the case of any course of dental treatment that was pre-approved under this Article XV in effect prior to October 1, 2000, which was in progress but not completed by October 1, 2000, the total payments made under this Article (before and after October 1, 2000) for the course of treatment will not be less than the pre-approved amount.

5. Notwithstanding the foregoing, 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 Section XV Paragraph 2 and this Paragraph 5. 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 Article XVII-B and the Eligible Employee will be required to reimburse the Plan in full for the cost of such duplicate services. For the avoidance of doubt, basic dental services do not include periodontia, 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.

ARTICLE XVI

GENERAL PROVISIONS

1. ***Proof of Claim***

(a) All benefits under the Plan shall be payable only upon receipt by the Plan Office in Baltimore, Maryland of written proof satisfactory to the Trustees covering the occurrence, character and extent of the event for which claim is made.

(b) No benefits shall be payable under Articles V, VI, VIII, XI, XII, XIV, and XV of the Plan unless notice of or claim for benefit is received by the Plan Office within twelve (12) months from the date service or treatment is rendered.

2. ***Examination***

Except in the case of the Life Benefit, the Trustees or their duly appointed representatives shall have the right and opportunity to examine the person of an Eligible Employee or his Dependent during the pendency of a claim hereunder and the right to an autopsy in the case of death (where such autopsy is not forbidden by law).

3. ***Payment of Claim***

Benefits hereunder shall be payable to the Eligible Employee; provided, however, that the Trustees, in their discretion, may pay such benefits to a provider of services or supplies, or to any person, including a dependent or beneficiary, who has paid the provider for such services, supplies, care or treatment for which benefits are payable under the Plan. Such payments shall constitute a full discharge of the liability of the Trustees to the extent of the benefits so paid.

Notwithstanding any provision to the contrary, if benefits become distributable under the Plan and the Plan Office is unable after a making a reasonable effort to locate the Eligible Employee, Pensioner, Dependent, or provider of service to whom the benefits are payable, the benefits of such Eligible Employee, Pensioner, Dependent, or provider of service shall be forfeited as of the end of the Plan Year that follows the Plan Year in which such benefits became distributable (or as soon as practicable thereafter). Similarly, if a check is issued to an Eligible Employee, Pensioner, Dependent, or provider of service but remains uncashed and, after making a reasonable effort, the Plan Office is unable to locate the person to whom the check was issued (or the person is located but fails or refuses to cash the check), the uncashed check of such person shall be forfeited as of the end of the Plan Year that includes the twelfth month after the date such check was issued. A record of the undeliverable amount (or uncashed check amount) shall be maintained and if such Eligible Employee, Pensioner, Dependent, or provider of service subsequently makes proper claim for such amounts, the amount shall be restored and shall be distributed to such person in accordance with terms of the Plan, but without any interest or earnings.

Notwithstanding the above, a non-PPO provider of No Surprises Services will receive an initial payment or notice of denial of payment for No Suprises Services within 30 calendar days of the Plan's receipt of the billed charges and all information necessary to adjudicate the claim.

4. ***Managed Care***

The Plan Administrator may, from time to time, authorize the reimbursement of medical or dental expenses which would not otherwise be covered by the Plan for the purpose of providing medical or dental care to an Eligible Employee, Pensioner or Dependent, as a result of an accidental bodily injury or disease, in a manner

which is less costly to the Plan than the medical or dental care which the individual would otherwise receive. Any request for such authorization must be approved prior to the date the expenses are incurred.

5. ***Non-Assignment of Benefits***

No person shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate any benefit payment under the Plan, and any such payment shall not be subject to any legal process to levy execution upon or attachment or garnishment proceedings against for the payment of any claims; provided, however, that an Eligible Employee or his Dependent may authorize the Plan to make payment directly to a provider of services for covered expenses hereunder or to an Employer, upon receipt of proof by the Plan that such Employer has made payment to the provider of services.

6. ***Limitation of Action***

Legal action to recover benefits under the Plan may not be filed before exhausting all administrative remedies provided under Sections 7 and 7A of this Article XVI, and may not be filed later than 12 months following the date of the Trustees' denial of an appeal. All legal actions filed against the Plan must be filed in the United States District Court for the District of Maryland.

7. ***Appeal Procedure (Applicable to claims prior to January 1, 2003 and thereafter applicable to all claims except claims for medical care in accordance with Section 733(a) of ERISA)***

A. Initial Claim

If a claimant (which for purposes of this section shall mean the actual claimant or, if duly authorized, such claimant's representative) files a claim for benefits and such claim is wholly or partially denied, the Plan Administrator shall, within 90 days (45 days for disability claims) of the date the claim for benefits was received, provide written notice to the claimant as specified in Subsection B below. If special circumstances require additional time for processing the claim, written notice of this extension of time shall be sent to the claimant within 90 (45 for disability claims involving matters beyond the control of the Plan) day period. Any such notice shall state the special circumstances and shall provide the date by which the Plan expects to render the benefit determination; and, in the case of a disability determination, shall explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, the additional information needed to resolve those issues, and that the claimant shall have at least 45 days to provide the specified information. Such extension shall not exceed 180 (75 days for disability claims) days from the date the claim was received; provided, however, with respect to disability claims: (1) an additional 30 day extension may be obtained due to matters beyond the control of the Plan if written notice of such second extension is provided to the claimant prior to the end of the first 30 day extension, specifying the circumstances requiring the extension and the date a decision is expected, and (2) the period for making the determination shall be tolled from any date of any extension which requests additional information from the claimant until the date such information is provided by the claimant.

B. Claim Denial

Any written notice sent by the Plan Administrator denying, in whole or in part, any claim, shall set forth in a manner to be understood by the Claimant:

(1) the specific reasons for the adverse determination;

(2) the specific provisions of the Regulations on which the determination is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) upon an adverse determination on review; and

(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 advise 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.

(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.

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.

D. Decision on Appeal

A decision on appeal shall be made by the Trustees (or a subcommittee thereof) at the regularly scheduled quarterly meeting of the Trustees which first occurs after the 30th day following receipt of the appeal by the Plan Administrator. The appeal may be delayed to the next regularly scheduled quarterly meeting if: (1) special circumstances require a further extension for processing and (2) the Plan Administrator provides written notice to the claimant of the extension, the special circumstances, and the date as of which the benefit determination will be made. Any claimant filing an appeal shall have the right to appear in person before the Trustees (or subcommittee). The Trustees (or subcommittee) hearing the appeal will consider the evidence presented and will listen to arguments for a reasonable period of time on behalf of the appeal. If any disability claim is based on a medical judgment, the Trustees (or subcommittee) will consult with a health care professional (who was not consulted in the initial benefit decision and is not the subordinate of any health care professional consulted in the initial benefit decision) who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts whose advice obtained on behalf of the Plan (even if not relied on) shall be identified if requested. The decision of the Trustees (or subcommittee) on an appeal shall be : (1) in writing; (2) final and binding on all parties; and (3) communicated not later than 5 days after the determination is made. The decision shall be written in a manner to be understood by the claimant and shall include:

(1) The specific reasons for the adverse determination;

(2) Reference to the specific provisions of the Regulations on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive upon request, without charge, reasonable access to and copies of all documents, records and other information relevant to the claim;

(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) In the case of disability benefits, (a) a copy of any internal rule, guideline, protocol or similar criterion relied upon in making the determination, and (b) an explanation of the scientific of clinical judgment for any determination based on medical necessity, experimental treatment or similar exclusion or limit.

(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.

7A. ***Appeal Procedure (Applicable to claims for medical care in accordance with Section 733(a) of ERISA effective January 1, 2003)***

A. General

Since the Plan contains no pre-approval requirements, all claims for medical care in accordance with Section 733(a) of ERISA ("claims") shall be Post-Service claims. Post-Service claims are claims after medical care is received.

B. Initial Claim

If a claimant (which for purposes of this section shall mean the actual claimant or, if duly authorized, such claimant's representative) files a claim for benefits and such claim is wholly or partially denied, the Plan Administrator shall, within the Initial Processing Period, provide written notice to the claimant as specified below. If special circumstances beyond the control of the Plan require additional time for processing the claim, written notice of this extension of time shall be sent to the claimant within the Initial Claim Extension Period. Any such notice shall state the special circumstances and shall provide the date by which the Plan expects to render the benefit determination. If such an extension is necessary in Post-Service claims due to the failure of the claimant to submit necessary information, the claimant shall be afforded at least 45 days from receipt of the notice to provide the specified information. The period for making the determination shall be tolled from the date of any such extension until the date on which the claimant responds to the request for additional information.

C. Claim Denial

Any written notice sent by the Plan Administrator denying, in whole or in part, any claim, shall set forth in a manner to be understood by the Claimant and shall include:

(1) the specific reasons for the adverse determination;

(2) the specific provisions of the Regulations on which the determination is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) upon an adverse determination on appeal;

(5) a copy without charge of any internal rule, guideline, protocol or similar criterion relied upon in making the adverse determination; and

(6) an explanation of the scientific or clinical judgment for any determination based on medical necessity or experimental treatment or similar exclusion or limit.

D. 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 180 days following receipt of a claim denial.

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.

E. Decision on Appeal

A decision on appeal for Post-service claims shall be made by the Trustees (or a subcommittee thereof) at the regularly scheduled quarterly meeting of the Trustees which first occurs after the 30th day following receipt of the appeal by the Plan Administrator. The appeal may be delayed to the next regularly scheduled quarterly meeting if: (1) special circumstances require a further extension for processing and (2) the Plan Administrator provides written notice to the claimant of the extension, the special circumstances, and the date as of which the benefit determination will be made. Any claimant filing an appeal shall have the right to appear in person before the Trustees (or subcommittee). The Trustees (or subcommittee) hearing the appeal will consider the evidence presented and will listen to arguments for a reasonable period of time on behalf of the appeal. If any claim is based on a medical judgment including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, those conducting the appeal will consult with a health care professional (who was not consulted in the initial benefit decision and is not the subordinate of any health care professional consulted in the initial benefit decision) who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts whose advise was obtained on behalf of the Plan (even if not relied on) shall be identified upon request. The decision of the Trustees (or subcommittee) on an appeal shall be: (1) in writing; (2) final and binding on all parties; and (3) communicated not later than 5 days after the determination is made. The decision shall be written in a manner to be understood by the claimant and shall include.

(1) The specific reasons for the adverse determination;

(2) Reference to the specific provisions of the Regulations on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive upon request, without charge, reasonable access to and copies of all documents, records and other information relevant to the claim;

(4) A statement of the claimant's right to bring an action under Section 502(a) of ERISA following the appeal; and

(5) (a) a copy of any internal rule, guideline, protocol or similar criterion relied upon in making the determination, and (b) an explanation of the scientific or clinical judgment for any determination based on medical necessity, experimental treatment or similar exclusion or limit.

F. Applicable Time Periods

The Initial Processing Period is within a reasonable period of time but not later than 30 days for Post Service claims.

The Initial Claim Extension Period is up to 15 days for Post-Service claims.

G. External Review

Effective January 1, 2022, if a claimant receives an adverse benefit determination that relates to a No Surprises Service, the claimant may be entitled to appeal the decision to an external independent review organization (IRO) within four months of the receipt of the adverse determination on appeal. External review is limited to claims involving whether the Plan is complying with the surprise billing and cost sharing protections under No Surprises Act. No other denials will be reviewed by an IRO unless otherwise required by law. Requests for external review are filed with the Plan Office.

All such external review requests shall, within five business days following the receipt of the external review request, receive a preliminary review to determine whether: the claimant is or was covered under the Plan at the time the health care item or service was provided; the request for external review concerns payment for No Surprises Services; the claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeal process; and the claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Fund Office will issue a written notification of its determination to the claimant, including, if applicable, the reason for the request's ineligibility for external review or a description of any information or materials necessary to perfect the request for external review. If additional information or materials are necessary, the claimant shall have until the later of the four-month filing period or 48 hours following receipt of the written notification to provide the additional information or materials.

Upon completion of a preliminary review that determines that the matter is eligible for external review under these procedures, the Plan Office shall refer the matter to an IRO. The determination of the IRO shall be binding except to the extent that other remedies may be available under Federal law. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination on appeal, the Plan shall immediately provide payment for the No Surprises Service claim.

8. ***Qualified Medical Child Support Orders***

(a) The Plan shall cover as a Dependent child any "alternate recipient" under a "qualified medical child support order" ("QMCSO"), as those terms are defined in and consistent with the provisions of Section 609 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). A child named in a QMCSO shall not have coverage under this Plan unless a parent of such child is an Eligible Employee.

(b) Upon receipt of a medical child support order within the meaning of ERISA Section 609(a)(2)(B), the Plan Administrator shall comply with the notice requirements of ERISA Section 609(a)(5). The Plan Administrator shall review such order and make a determination as to whether or not such order is a QMCSO.

(c) An alternate recipient may designate a representative to receive copies of any notices required to be sent under this Section.

(d) If the alternate recipient or his custodial parent or legal guardian pays any expenses directly to a service provider and is thereby entitled to benefits under this Plan via a direct reimbursement to such alternate recipient, parent or guardian, then upon presentation of proof that such expenses have been paid, reimbursement shall be made directly to such alternate recipient, parent or guardian and not to the Eligible Employee.

9. ***Compliance with HIPAA***

The Administrator, the Trustees and any individual designated by the Administrator or the Trustees may use and/or disclose any Protected Health Information as defined in 45 C.F.R. § 164.501 which may be received from the Plan without first obtaining a written authorization from a Participant, or otherwise providing an opportunity for the Participant to agree or object, in the situations described in 45 C.F.R. § 164.512, for all purposes of Plan administration, consistent with 45 C.F.R. Part 164, Subpart E. The provisions of 45 C.F.R. § 164.504(f) (2) are hereby incorporated by reference into the Plan.

10. ***Medical Benefits Grandfathered Status***

The Trustees hereby designate and intend to maintain the medical benefits described in the Plan as a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act of 2010.

ARTICLE XVII

NON-DUPLICATION OF BENEFITS

1. If an Eligible Employee (or his Dependent) or a Pensioner (or his Dependent) is entitled to benefits under this Plan and any other plan, the amount of benefits provided by this Plan for that care may be reduced, as explained in Order of Payment, to the extent that the total payment provided by all plans will not be more than 100% of any necessary, Allowable item of expense covered by this Plan or any of the other plans. However, in no event shall the benefits payable under this Plan exceed the benefits that would have been payable in the absence of this provision.

   Any item of expense covered by Medicare or a "no-fault" motor vehicle plan is subject to a further requirement, that such item will be considered in determining benefits under this provision only if the cost of the item is covered by this Plan as well as Medicare or a "no-fault" motor vehicle plan.

2. For purposes of this Article XVII, the term *"plan"* shall mean any plan that provides health, medical, disability, dental, optical or hearing aid coverage:

   (a) by group insurance, or by any other method of coverage for persons in a group;

   (b) by an individual or self-pay plan which contains a non-duplication of benefits provision;

   (c) by any governmental plan;

   (d) by a "no-fault" motor vehicle plan; or

   (e) as required by applicable law.

3. The term *"Medicare"* shall mean TITLE XVIII of the Federal Social Security Act, as it now is or is later changed. A person who is eligible for coverage under Medicare shall be deemed to have all the coverage for which he or she is eligible under Medicare.

4. The term *"No-Fault Motor Vehicle Plan"* means a compulsory motor vehicle plan that provides payments for medical or dental care which are payable, in whole or in part, without regard to fault.

5. The term "Order of Payment" applies to a person who is covered under two or more plans, in which case the rules below will apply to decide which plan's benefits are payable first. The Plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan will pay, in accordance with its terms, any expenses that remain beyond the primary plan benefits, up to the maximum amount that the secondary plan would pay if there was no coordination of benefits; and, the secondary plan may credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

   (a) **Non Duplication -** Notwithstanding the provisions below, if a plan does not have a *"Non-Duplication of Benefits"* provision or has order of payment provisions that are inconsistent with these rules, it will be the primary plan..

   (b) **Non-Dependent or Dependent -** A plan that covers a person other than as a dependent is the primary plan and a plan that covers that person as a dependent is the secondary plan.

(c) **Dependent Child Covered Under More Than One Plan** – Unless there is a court decree stating otherwise, the order of payment will be as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year (without regard for the year of birth) is the primary plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the primary plan.

(2) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(ii) 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 Subparagraph (1) of this paragraph (c) shall determine the order of payment;

(iii) If a court decree states that both 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 Subparagraph (1) of this paragraph (c) shall determine the order of payment; or

(iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
(I) The plan covering the custodial parent;
(II) The plan covering the custodial parent's spouse;
(III) The plan covering the non-custodial parent; and then
(IV) The plan covering the non-custodial parent's spouse.

(3) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of payment shall be determined, as applicable, under Subparagraph (1) or (2) of this paragraph (c) as if those individuals were parents of the child.

(d) **Active Employee or Retired Employee**

(1) The Plan that covers a person as an active employee (an employee who is not retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired employee or as a dependent of a retired employee is the secondary plan.

(2) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

(3) This rule does not apply if the rule in paragraph (b) can determine the order of payment.

(e) **COBRA or State Continuation Coverage**

(1) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an active employee or retiree or a dependent of such person is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

(2) 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.

(3) This rule does not apply if the rule in paragraph (b) can determine the order of payment.

(f) **Longer or Shorter Length of Coverage**

(1) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(2) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

(3) The start of a new plan does not include:

(a) A change in the amount or scope of a plan's benefits;

(b) A change in the entity that pays, provides or administers the plan's benefits; or

(c) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

(4) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(g) "Allowable expenses," which are the only expenses payable in accordance with these Order of Payment rules, are health care expenses, including deductibles, coinsurance and copayments that are covered, at least in part, by any plan covering the covered person or his/her dependents. An expense that is not covered by any plan covering the covered person or his/her dependents is not an allowable expense; and any expense that a provider is prohibited from charging a covered person or his/her dependents, whether by law or contractual agreement, is not an allowable expense.

(h) If none of the preceding rules determines the order or benefits, the allowable expenses shall be shared equally between the plans.

6. To administer claims, this Plan, without the consent of any person, shall have the right to:

(a) give or obtain any data needed to determine benefits under this provision;

(b) recover any sum paid above that required by this provision;

(c) pay any organization the sum it paid, but which should have been paid by this Plan. Amounts so paid shall be deemed benefits paid under this Plan, and to the extent so paid there will be no more liability under this Plan.

ARTICLE XVII-A

REIMBURSEMENT AND SUBROGATION

1. If benefits ("Benefits") are or may be paid by the Plan on behalf of an Eligible Employee (including a Pensioner) or a Dependent (collectively, "Covered Person") because of any illness or injury, or suspected illness or injury (collectively, "Injury"), for which another person or entity ("Other Person") (including, but not limited to, any insurer, except an insurer on a policy of insurance issued to and in the name of the Covered Person) may have any financial liability or responsibility, the Plan is entitled to be reimbursed by the Covered Person for the lesser of (i) the full amount of the Benefits the Plan pays, and (ii) the total amount the Covered Person recovers, on account of such Injury regardless of the legal fees, costs, or expenses incurred by the Covered Person, and regardless of how the recovered amount may be characterized (e.g., medical costs or expenses). Acceptance of Benefits under this Plan by the Covered Person constitutes an acknowledgement of the Plan's rights under this Article, as well as an assignment to the Plan of, and a grant to the Plan of a constructive trust, lien, and/or equitable lien by agreement on, any recovery by the Covered Person (including an agent or attorney receiving a payment on behalf of a Covered Person), to the extent necessary to reimburse the Plan as required by this Article. The Covered Person shall execute and deliver such instruments and take such actions as the Plan may require to protect the Plan's rights. The Covered Person shall do nothing to prejudice the Plan's rights without the Plan's express written consent.

   The Covered Person is required to notify the Plan within ten (10) days of any accident or Injury for which a third party or parties may be liable. The Plan must be notified within ten (10) days of the initiation of any lawsuit or settlement negotiations relating to the accident and of the conclusion of any settlement, judgment or payment relating to the accident to protect the Plan's claims (unless the foregoing relates to an insurer on a policy of insurance issued to and in the name of the Covered Person).

   If the Covered Person receives any Benefits from the Plan for any Injury, the Plan is subrogated to all rights of recovery available to the Covered Person arising out of any claim, demand, cause of action or right of recovery that has accrued, may accrue or which is asserted in connection with such Injury, to the extent of any and all related payments of Benefits made or to be made by the Plan on the Covered Person's behalf.

   The Plan's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the illness or injury, and regardless of whether the Covered Person actually receives the full amount of such judgment, award, settlement, compromise, insurance or order. The Plan's rights of reimbursement and subrogation provide the Plan with first priority to any and all recovery in connection with the illness or injury, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified.

   The Plan has a constructive trust, lien, and/or equitable lien by agreement in favor of the Plan on any amount received by the Covered Person or a representative of the Covered Person (including an attorney) that is due to the Plan under this Article, and any such amount is deemed to be held in trust by the Covered Person for the benefit of the Plan until paid to the Plan. The Covered Person hereby consents and agrees that a constructive trust, lien, and/or equitable lien by agreement in favor of the Plan exists with regard to any payment, amount and/or recovery from a third party (excluding an insurer on a policy of insurance issued to and in the name of the Covered Person). In accordance with that constructive trust, lien, and/or equitable lien by agreement, the Covered Person agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

   Consistent with the Plan's rights set forth in this Article, if the Covered Person submits claims for or receives any Benefits from the Plan for an Injury that may give rise to any claim against any third party, the Covered Person will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" ("Subrogation Agreement") affirming the Plan's rights of reimbursement and subrogation with respect to such

Benefits and claims. This Subrogation Agreement also must be executed by the Covered Person's attorney, if applicable. However, even if the Covered Person or a representative of the Covered Person (including the Covered Person's attorney) does not execute the required Subrogation Agreement and the Plan nevertheless pays Benefits to or on behalf of the Covered Person, the Covered Person's acceptance of such Benefits shall constitute the Covered Person's agreement to the Plan's right to subrogation or reimbursement from any recovery by the Covered Person from a third party (excluding an insurer on a policy of insurance issued to and in the name of the Covered Person) that is based on the circumstance from which the expense or Benefit paid by the Plan arose, and the Covered Person's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Plan on any payment amount or recovery that the Covered Person recovers from a third party (excluding an insurer on a policy of insurance issued to and in the name of the Covered Person).

Because benefit payments are not payable unless the Covered Person signs a Subrogation Agreement, the Covered Person's claim will not be considered filed and will not be paid if the period for filing claims passes before the Subrogation Agreement is received.

Coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recovered by, or on behalf of, the Covered Person in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment the Covered Person or the Covered Person's attorney may receive as a result of the Injury, no matter how these amounts are characterized or who pays these amounts, as provided in this Article, are excluded under the Plan.

The Covered Person is obligated to take all necessary action and cooperate fully with the Plan in its exercise of its rights of reimbursement and subrogation, including notifying the Plan of the status of any claim or legal action asserted against any party or insurance carrier and of the Covered Person's receipt of any recovery (unless the foregoing relates to an insurer on a policy of insurance issued to and in the name of the Covered Person). If the Covered Person is asked to do so, the Covered Person must contract the Plan Office immediately. The Covered Person must also do nothing to impair or prejudice the Plan's rights without the express written consent of the Plan. For example, if the Covered Person chooses not
to pursue the liability of a third party, the Covered Person may not waive any rights covering any conditions under which any recovery could be received. Where the Covered Person chooses not to pursue the liability of a third party, the acceptance of Benefits from the Plan authorizes the Plan to litigate or settle the Covered Person's claims against the third party. If the Plan takes legal action to recover what it has paid, the acceptance of Benefits obligates the Covered Person (and the Covered Person's attorney, if applicable) to cooperate with the Plan in seeking its recovery, and in providing relevant information with respect to the Injury.

The Covered Person must also notify the Plan before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit (unless the foregoing relates to an insurer on a policy of insurance issued to and in the name of the Covered Person). If the Covered Person does not, and the Covered Person accepts payment that is less than the full amount of the Benefits the Plan has advanced, the Covered Person will still be required to repay the Plan, in full, for any Benefits it has paid. The Plan may withhold Benefits if the Covered Person waives any of the Plan's rights to recovery without the express written consent of the Plan or fails to cooperate with the Plan in any respect regarding the Plan's reimbursement and subrogation rights.

2. The Plan has an independent right to bring an action in connection with an Injury in the Covered Person's name and also has the right to intervene in any suit filed by the Covered Person against any Other Person in which the Covered Person asserts a claim for any recovery related to an Injury for which the Plan has paid or may pay Benefits; however, the Plan is not required to do so to protect its rights under this Article.

3. If the Covered Person refuses to reimburse the Plan from any recovery or refuses to cooperate with the Plan regarding its subrogation or reimbursement rights, the Plan has the right to recover the full amount of all Benefits paid by any and all other methods which include, but are not necessarily limited to, offsetting the amounts paid against the Covered Person's future payments of Benefits under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation Agreement and the failure of any party to respond

to the Plan's inquiries concerning the status of any claim or any other inquiry relating to the Plan's rights of reimbursement and subrogation

If an Other Person does not voluntarily compensate the Covered Person and if the Covered Person has not filed suit against the Other Person, the Plan has the right to file suit against any Other Person in the name of the Covered Person to recover the full amount of all Benefits the Plan paid or may pay related to an Injury. If the Plan files suit against an Other Person, the Plan's expenses of recovery (including attorney's fees) will be paid out of any recovery in such suit.

If the Plan is required to pursue legal action against the Covered Person to obtain repayment of the Benefits advanced by the Plan, the Covered Person shall pay all costs and expenses, including attorney's fees and costs, incurred by the Plan in connection with the collection of any amounts owed the Plan or the enforcement of any of the Plan's rights to reimbursement. In the event of legal action, the Covered Person shall also be required to pay interest at the rate determined by the Trustees from time to time from the date the Covered Person becomes obligated to repay the Plan through the date that the Plan is paid the full amount owed. The Plan has the right to file suit against the Covered Person in any state or federal court that has jurisdiction over the Plan's claim.

In the case of a deceased Covered Person, the Plan's rights apply to the decedent's estate and the estate is required to comply with the Plan's rules and procedures to the same extent as a Covered Person. The Plan's right to reimbursement applies to any funds recovered from any other party by or on behalf of the estate and to any wrongful death recovery received by the decedent's survivors.

4. The Plan's right to reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, the "attorney's fund" doctrine, regulatory diligence or any other defenses or doctrines that may affect the Plan's right to reimbursement. Although the Plan requires full reimbursement for all Benefits paid on behalf of the Covered Person, there may be special circumstances under which full reimbursement may be waived by the Trustees, and the Trustees may determine that the Plan will accept partial reimbursement. In determining whether such circumstances exists, the Trustees may consider the likelihood of success in litigation, the amount of the Other Person's insurance, extent of disability, lost wages, attorney's fees, and any other factors deemed relevant by the Trustees.

ARTICLE XVII-B

OVERPAYMENTS

If the Plan pays benefits ("Benefits") in excess of the amount payable in accordance with the terms of the Plan, whether on the basis of the Plan's error or the error or false statements of an Eligible Employee, Dependent, Pensioner, a provider or a third party, or if the Plan advances Benefits that a Covered Person is required to reimburse because, for example, the Covered Person has received a third party recovery (see Article XVII-A), the Covered Person is required to reimburse the Plan in full and the Plan shall be entitled to recover any such benefits.

The Plan has a constructive trust, lien, and/or an equitable lien by agreement in favor of the Plan on any overpaid or advanced Benefits received by the Covered Person or a representative of the Covered Person (including an attorney) that is due to the Plan under this Article, and any such amount is deemed to be held in trust by the Covered Person for the benefit of the Plan until paid to the Plan. By accepting Benefits from the Plan, the Covered Person consents and agrees that a constructive trust, lien, and/or equitable lien by agreement in favor of the Plan exists with regard to any overpayment or advancement of Benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, the Covered Person agrees to cooperate with the Plan in reimbursing it for all of its costs and expenses related to the collection of those Benefits.

Any refusal by the Covered Person to reimburse the Plan for an overpaid amount will be considered a breach of the Covered Person's agreement with the Plan that the Plan will provide the Benefits available under the Plan and the Covered Person will comply with the rules of the Plan. By accepting Benefits from the Plan, the Covered Person affirmatively waives any defense the Covered Person may have in any action by the Plan to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

If the Covered Person refuses to reimburse the Plan for any overpaid amount, the Plan has the right to recover the full amount owed by any and all methods which include, but are not necessarily limited to, offsetting the amounts paid against any future Benefits otherwise payable to or on behalf of such Employee, Dependent, Pensioner or any other person covered under the Plan as a member of such person's family.

The Plan also may recover any overpaid or advanced Benefits by pursuing legal action against the party to whom the Benefits were paid. In the event it is necessary for the Trustees to file suit against an Eligible Employee, Dependent, Pensioner, a provider or other party, in order to collect any amount owed to the Plan arising out of or related to an overpayment or erroneous payment, such Eligible Employee, Dependent, Pensioner, provider or other party shall reimburse the Trustees for all reasonable attorneys' fees and costs of suit, and other professional fees and costs expended in connection with the Trustees' collection of any amounts owed to the Plan or the enforcement of any of the Plan's rights to reimbursement. In the event of legal action, the Covered Person shall also be required to pay interest at the rate determined by the Trustees from time to time from the date the Covered Person becomes obligated to repay the Plan through the date that the Plan is paid the full amount owed. The Plan has the right to file suit against the Covered Person in any state or federal court that has jurisdiction over the Plan's claim.

In the case of a deceased Covered Person, the Plan's rights apply to the decedent's estate and the estate is required to comply with the Plan's rules and procedures to the same extent as a Covered Person. The Plan's right to reimbursement applies to any funds recovered from any other party by or on behalf of the estate and to any wrongful death recovery received by the decedent's survivors.

ARTICLE XVIII

DEFINITIONS

1. The term *"**Dependent**"* shall mean

(a) ***Spouse***. The spouse of an Eligible Employee; any benefit otherwise payable with respect to such spouse shall cease upon date of divorce or legal separation from the Eligible Employee. The term *"legal separation"* shall include any separation pursuant to a court order or written contract between the Employee and spouse.

(b) ***Natural and Adopted Children***. The Eligible Employee's natural or adopted child under age 26.

(c) ***Stepchildren***.

(i) General. Each unmarried legal stepchild of an Eligible Employee who is under the age of nineteen (19), is a member of the household of the Eligible Employee and is dependent upon him for support. A stepchild under fifteen (15) days of age shall also be considered a Dependent for hospital, surgical and medical services required for treatment of the child's illness.

(ii) Age 19 or older but less than age 23. Each unmarried legal stepchild of an Eligible Employee who is age nineteen (19) but less than twenty-three (23) years, is attending school on a full-time basis and is dependent upon the Eligible Employee for his principal support and maintenance. School vacation periods during any calendar year which interrupt but do not terminate what otherwise would have been a continuous course of study in that calendar year shall be considered a part of school attendance on a full-time basis. Certification of full-time school enrollment will be required annually to continue the Dependent's enrollment in the Plan.

(iii) Stepchild's Medical Leave from School. A Dependent stepchild, who is enrolled in post-secondary education immediately before a medically necessary leave of absence, as certified by the Dependent stepchild's attending physician, shall have coverage under the Plan extended during such leave of absence until the earlier of: (i) the one-year anniversary of the date on which the Dependent stepchild's leave of absence began, or (ii) the date on which the Dependent stepchild's coverage under the Plan would otherwise terminate. The extended coverage under this paragraph will run concurrent with the Plan's COBRA continuation coverage.

(d) ***Grandchildren***

(i) General. Each unmarried grandchild of an Eligible Employee who is under the age of nineteen (19), is a member of the household of the Eligible Employee and is dependent upon the Eligible employee for support; provided that:

(A) the Eligible Employee has been awarded long term legal custody of the grandchild by a court or appropriate state agency;

(B) the Eligible Employee has been unable to adopt the grandchild due to circumstances beyond the Employee's control;

(C) the Eligible Employee claims the grandchild as a dependent on the Employee's federal income tax return; and

(D) both parents of the grandchild are totally disabled, incarcerated or deceased, or are otherwise unable to care for the grandchild.

(ii) Age 19 or older but less than age 23. Each unmarried grandchild of an Eligible Employee who is age nineteen (19) but less than twenty-three (23) years, is attending school on a full-time basis and is dependent upon the Eligible Employee for his principal support and maintenance, and provided such grandchild also meets the requirements of subsections (d)(i)(A) through (D) above. School vacation periods during any calendar year which interrupt but do not terminate what otherwise would have been a continuous course of study in that calendar year shall be considered a part of school attendance on a full-time basis. Certification of full-time school enrollment will be required annually to continue the Dependent's enrollment in the Plan.

(iii) Grandchild's Medical Leave from School. A Dependent grandchild, who is enrolled in post-secondary education immediately before a medically necessary leave of absence, as certified by the Dependent grandchild's attending physician, shall have coverage under the Plan extended during such leave of absence until the earlier of: (i) the one-year anniversary of the date on which the Dependent grandchild's leave of absence began, or (ii) the date on which the Dependent grandchild's coverage under the Plan would otherwise terminate. The extended coverage under this paragraph will run concurrent with the Plan's COBRA continuation coverage.

(e) ***Disabled Children***. The coverage of an unmarried child shall not cease because of attainment of the termination age specified in the Plan while the Eligible Employee's coverage is in force and the child otherwise qualified as a Dependent, if such child: (i) is incapable of self-sustaining employment by reason of mental or physical disability; and (ii) became so incapable prior to attainment of the maximum age limit specified in the Plan.

(f) ***Qualified Medical Child Support Order***. A child of an Eligible Employee who is named in a Qualified Medical Child Support Order (as determined under Section 8 of Article XVI) shall be a Dependent child hereunder to the extent provided for under such Order.

(g) ***Parent***. A parent of an Eligible Employee who qualifies as a Dependent under rules established by the Trustees.

2. The term *"Disability"* or *"Disabled"* shall mean such physical condition as to make an Eligible Employee unable to obtain work as a licensed officer.

3. The term "Eligible Employee" shall mean any Employee who continues to satisfy the eligibility criteria for benefits under the Plan, as set forth in Article I hereof.

4. The term "Employee" shall mean each of an Employer's employees for whom the Union is the collective bargaining representative, but including each member in good standing of the Union (including officials and representatives) employed by the Union or by District No. 1 – Pacific Coast District, MEBA and any of its affiliates when such Union or District No. 1-Pacific Coast District, MEBA and any of its affiliates is an Employer as defined below. The term may include when applicable under Articles II, XVI and XVII or elsewhere hereunder, such an employee who qualifies for a pension from the MEBA Pension Trust and employees of the Union, District No. 1-Pacific Coast District, MEBA and any of its affiliates, the American Maritime Congress and the MEBA Pension, Medical and Benefits, Vacation and Training Plans, who are not covered by collective bargaining agreement and for whom contributions are made to the MEBA Medical and Benefits Plan as determined by the Trustees. The term *"Employees"* may, when applicable, be deemed to include Pensioners who had, prior to retirement, been in covered employment.

5. The term "Employer" shall mean any of the various Employers of licensed marine officers for whom the Union is the collective bargaining representative and who are or who may hereafter become signatories to the Agreement and Declaration of Trust establishing the MEBA Pension and Welfare Plan dated August 1, 1950, requiring contributions to the Plan, including for the purpose of benefit coverage hereunder the Union, District No. 1-Pacific Coast District, MEBA and any of its affiliates while such Union or District No. 1-Pacific Coast District, MEBA and any of its affiliates is a party to said Agreement and Declaration of Trust, the American

Maritime Congress, the MEBA Pension, Medical and Benefits, Vacation and Training Plans, and Employers who are obligated by collective bargaining agreement to make the necessary contributions to the Plan on behalf of covered employees.

6. The term *"Pensioner"* shall mean

   (a) Any Eligible Employee receiving or entitled to receive benefits from the MEBA Pension Trust and who is a *"Pensioner"* as defined in Section 1.27 of the MEBA Pension Trust Regulations, and shall include District No. 1-Pacific Coast District, MEBA Staff Plan Pensioners who were Eligible Employees prior to their retirement. Pensioner also includes any Eligible Employee who is deemed to have earned sufficient pension credits under Section 2(f) of Article VIII so as to be entitled to benefits under Section 2(a) or 2(b) of Article VIII.

   (b) Pensioner shall not include any person who earned a majority of his pension credit under the MEBA Pension Trust in covered employment under a collective bargaining agreement between an Employer and the ROU or as an employee of the ROU or the ROU benefit plans, unless such person had at least 1,700 days of work in covered employment under a collective bargaining agreement between an Employer and District No. 1-Pacific Coast District, MEBA, which was taken into account for determining his pension credit under the MEBA Pension Trust.

7. The term *"Plan"* shall mean the rules and regulations of the MEBA Medical and Benefits Plan, as amended through Amendment No. 92-4, and as from time to time thereafter amended.

8. The term *"Trustees"* shall mean the Employer Trustees and Union Trustees of the Plan, collectively, and shall include their alternates when acting as Trustees.

9. The term *"Union"* shall mean the National Marine Engineers Beneficial Association, AFL-CIO.

ARTICLE XIX

PLAN INTERPRETATION AND BENEFIT DETERMINATION

The Trustees shall have complete authority, in their sole and absolute discretion, to (i) interpret the terms of the Trust, the Plan, any insurance contracts or policies (and any related documents and underlying policies) and (ii) determine eligibility for, and the amount of, benefits under the Plan. All such interpretations and determinations of the Trustees shall be final and binding upon all parties and persons affected thereby.

AMENDMENT AND TERMINATION

In order that the Trustees may carry out their obligation to maintain within the limits of the funds available to them a sound economic program dedicated to providing the maximum benefits for Eligible Employees (and their Dependents and beneficiaries), the Trustees expressly reserve the right, in their sole and absolute discretion and without notice to Employees, Employers, the Union or others affected hereby, at any time and from time to time, to:

(a) terminate or amend either the amount or conditions with respect to any Plan benefit, even though such termination or amendment affects claims that may have already accrued;

(b) alter or postpone the payment method of any Plan benefit;

(c) amend or modify any other provisions of the Plan;

(d) interpret the provisions of the Plan (and any related documents and underlying policies); and

(e) terminate the Plan, in whole or in part, at any time and for any reason.

Any such action or actions shall be final and binding upon Eligible Employees (and their Dependents) and Pensioners (and their Dependents).

SCHEDULE A

Life Benefit …… $ 10,000.00

SCHEDULE B

Supplementary Life Benefit …… $ 30,000.00

SCHEDULE C

Accidental Death & Dismemberment Benefit
(Full Amount) …… $ 10,000.00

SCHEDULE D

Supplementary Accidental Death & Dismemberment Benefit
(Full Amount) …… $ 30,000.00

SCHEDULE E

Weekly Disability Benefit …… $ 170.00
Maximum Payment…..……$ 6,630.00

SCHEDULE F
MAJOR MEDICAL EXPENSE COVERAGE FOR ELIGIBLE EMPLOYEES AND DEPENDENTS

Co-Insurance

The Eligible Employee shall be responsible for Covered Medical Expenses, as described in Article VI, to the extent of 40% for non-PPO providers, except as described in Article VI, Sections 3(n) and 9(b). When participating PPO providers are used, and as described in Article VI, Sections 3(n) and 9(b), when non-PPO providers provide certain services, the Eligible Employee shall be responsible for 10% of hospital charges and 20% of medical charges, after applicable co-pays. Notwithstanding anything in this Schedule to the contrary, No Surprises Services received by an Eligible Employee will be covered subject to the Plan's applicable Cost Sharing.

SCHEDULE G

ANNUAL DEDUCTIBLE FOR ELIGIBLE EMPLOYEES AND DEPENDENTS

The Annual Deductible amount is $ 250.00 per individual or $ 500.00 per family per calendar year.

SCHEDULE H

Effective January 1, 2006, when a Pensioner's gross monthly pension, calculated as a straight life annuity, is less than $ 1,000.00, the Pensioner shall be reimbursed for the amount of Medicare Part B premiums he actually paid for Part B coverage for himself and his Dependents, provided the Pensioner provides proof of payment of such premiums in the manner prescribed by the Trustees.

SCHEDULE I

MAJOR MEDICAL EXPENSE COVERAGE FOR PENSIONERS AND DEPENDENTS

The Pensioner shall be responsible for Covered Medical Expenses, as described in Article VIII, to the extent of 40% for non-PPO providers, except as described in Article VI, Section 3(n) and Article VIII, Section 2(d)(2), when non-PPO providers provide certain services. When participating PPO providers are used, the Pensioner shall be responsible for 10% of hospital charges and 20% of medical charges after applicable co-pays. Notwithstanding anything in this Schedule to the contrary, No Surprises Services received by a Pensioner will be covered subject to the Plan's applicable Cost Sharing only to the extent otherwise covered for Pensioners and their Dependents or as may be required by the No Surprises Act.

SCHEDULE J

The Annual Deductible amount is $ 250.00 per individual or $ 500.00 per family per calendar year.

SCHEDULE K

Life Benefit for Pensioners……$ 1,500.00

SCHEDULE L

ANNUAL CUMULATIVE PER PERSON MAXIMUM APPLICABLE TO CERTAIN* MAJOR MEDICAL EXPENSES

Beginning on January 1, 2011 and ending on December 31, 2013, the Plan shall provide an annual maximum cumulative payment per person for certain* major medical expenses incurred in a calendar year (January 1 through December 31). The annual maximum payment per person shall be the amount shown for the following calendar years:

- for the 2011 calendar year the annual maximum shall be $750,000;
- for the 2012 calendar year the annual maximum shall be $1.25 million; and
- for the 2013 calendar year the annual maximum shall be $2 million.

For 2014 and subsequent calendar years the annual maximum shall no longer apply.

*The annual maximum shall apply to covered medical expenses as identified in Article VI (Major Medical Expense Coverage for Eligible Employees and Dependents) and in Article XI (Optical Benefit).

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