MEBA Benefit Plans
Safeguarding MEBA Members and Families

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December 2025

TO: Participants in the MEBA Medical and Benefits Plan
FROM: Patricia Kelly, Executive Director
RE: Summary Plan Descriptions

Enclosed please find a new Summary of Plan Description ("SPD") for the MEBA Medical and Benefits Plan. This SPD, which includes the updated MEBA Medical and Benefits Plan Regulations, should be inserted into your three-ring binder behind the "Medical" tab. Any existing materials behind that tab relating to the MEBA Medical and Benefits Plan should be removed and discarded.

Also enclosed is an updated Delta Dental Evidence of Coverage. This document should be inserted behind the "Dental" tab, if your binder includes a separate tab for dental benefits. If not, please insert it behind the "Medical" tab. Again, any existing materials behind that tab relating to the MEBA Medical and Benefits Plan should be removed and discarded.

If you do not have a binder, please contact our office and one will be provided to you. If you previously given a binder and need a replacement, there will be a charge for the replacement.

Please feel free to contact us if you have any questions.

Patricia Kelly
Executive Director

MEBA Medical and Benefits Plan

Summary Plan Description

December 1, 2025

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Introduction

If you have any questions about the MEBA Medical and Benefits Plan, your participation in it, please contact the Plan Office in Baltimore in writing.

About Your Summary Plan Description

The MEBA Medical and Benefits Plan ("Medical Plan" or "Plan") provides medical, prescription drug, dental, mental health and substance abuse, disability, life and accidental death and dismemberment benefits, optical, and hearing aid benefits in accordance with the MEBA Medical and Benefits Plan Rules and Regulations ("Rules and Regulations"). The Rules and Regulations are explained in this Summary Plan Description ("SPD"). This SPD covers only the major provisions of the Medical Plan, which should make it easier to read than the full Rules and Regulations. There have been many changes to the Plan since we last published the SPD. We have kept you apprised of all these changes through the issuance of Summaries of Material Modifications, which have all been incorporated into this SPD.

Please understand that no general explanation can adequately provide all the details of the Medical Plan. Therefore, this SPD does not change or otherwise interpret the terms of the official Medical Plan documents, such as the Agreement and Declaration of Trust Establishing the MEBA Welfare Plan ("Trust Agreement") or the Rules and Regulations. Your rights can be determined only by referring to these official documents, which are available for your inspection as described in the "Enforce Your Rights" section of this SPD. Please note that nobody other than the Board of Trustees of the MEBA Medical and Benefits Plan ("Board of Trustees" or "Trustees") has any authority to interpret the Rules and Regulations (or other official Medical Plan documents) or to make any promises to you about your benefits under the Medical Plan. If you have any questions about your Medical Plan benefits, do not rely on anyone's oral advice, but write to the Plan Office and you will receive a written reply to your inquiry.

This SPD does not override the Plan's Rules and Regulations. Only the Rules and Regulations and the other official Medical Plan documents govern the operation of the Medical Plan and the benefits to which you may be entitled. This SPD is supplied solely for the purpose of assisting you in comprehending the scope and meaning of the Medical Plan, not to replace or

amend it. This SPD replaces and supersedes the prior SPD.

If any of the information contained in this SPD is inconsistent with the official Medical and Benefits Plan documents, the provisions of the official documents will govern in all cases. The Board of Trustees reserves the right to amend, modify or terminate the Medical and Benefits Plan and the Rules and Regulations (in whole or in part) at any time and from time to time, subject to the limitations set forth in the Trust Agreement.

No individual shall have vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

No Surprises Act

Effective January 1, 2022, the Plan was amended to reflect the requirements of the No Surprises Act of the 2021 Consolidated Appropriations Act ("No Surprises Act"). As required by the No Surprises Act, the Plan covers charges for "No Surprises Act Services" (as defined in Appendix B of this SPD). Please see Appendix B of this SPD for additional information.

Affordable Care Act

The Trustees believe the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health care services without any cost sharing. However, the Plan, as a grandfathered health plan, must comply with certain consumer protections in the Affordable Care Act, for example, the prohibition of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (410) 547-9111. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act.This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Medical Coverage

We know that maintaining good health is important to you and your family. That's why the Medical Plan provides medical coverage to help pay the cost of health care for you and your qualified dependents.

The Plan's medical coverage reimburses you for all or part of a broad range of medical expenses you or your qualified dependents may incur.

In order to counter the rising costs of medical benefits, the Plan uses CareFirst BlueCross BlueShield as a Preferred Provider Organization ("PPO"). CareFirst BlueCross BlueShield is one of the nation's largest networks of doctors and hospitals. If you use providers within the PPO network, you will be reimbursed at higher rates and both you and the Medical Plan will benefit from bigger discounts. The Medical Plan also uses a Prescription Drug Plan ("PDP") to keep down the cost of prescription drug coverage while providing you with excellent coverage and service – OptumRx is the Medical Plan's PDP.

Dental Coverage

Maintaining good dental health is important to your overall well-being. That's why the Medical Plan also provides dental coverage to help pay the cost of dental services for you and your qualified dependents while you are eligible for active employee coverage or, for pensioners, upon your timely election of dental benefits upon qualification for a pension from the MEBA Pension Trust.

The Medical Plan's dental coverage is provided by Delta Dental. Delta Dental operates the nation's largest network of participating dentists. After meeting an annual deductible, treatment you receive from in-network dentists costs you only a small co-pay. If you wish, you may receive treatment from out-of-network dentists. If you do, Delta Dental will reimburse you based on the allowable charge for the services performed and you pay a co-pay and any additional charges.

Please note, dental coverage is available to pensioners who have retiree medical coverage and their dependents only if they timely elect to receive retiree dental benefits during their one opportunity to opt-in. Retirees must pay the full cost of retiree dental benefits.

Life, Accidental Death and Accidental Dismemberment Coverages

Peace of mind is not something you can come by easily, especially when you try to plan for the uncertainties of the future. The Medical Plan provides Life, Accidental Death and Accidental Dismemberment Benefits that can help by providing valuable benefits for you and your family if you die or if you're seriously injured in an accident.

Optical Coverage

The Optical Coverage is designed to help you and your dependents maintain eye health through regular exams and provide allowance for corrective eyewear.

Hearing Aid Coverage

The Hearing Aid Coverage is designed to support you, and your dependents in managing hearing health. The Plan provides coverage toward the cost of hearing aids and hearing-related examinations.

Coverage by the MEBA Medical and Benefits Plan

"***Covered Employment***" *is employment with a Participating Employer and vacation time for which you*

Who Is Eligible

Employee Coverage

As a new entrant into the Medical Plan, you become covered on the date you complete 30 days of Covered Employment in any six consecutive calendar months.

receive benefits from the MEBA Vacation Plan.

*A "**Participating Employer**" is any Employer that is obligated under a collective bargaining agreement or a participation* agreement to make contributions to the Medical and Benefits Plan.

You will maintain your eligibility under the Medical Plan if you complete a second period of 30 days of Covered Employment within a period of six consecutive calendar months as long as this second period of Covered Employment falls within your first year of participation. Thereafter, in order to maintain eligibility, you must complete 60 days on the payroll in Covered Employment within any period of six consecutive calendar months. Absence from work due to any health factor (e.g., sick leave or hospitalization) is not treated as being in Covered Employment for purposes of counting the days for eligibility. Days of attendance at the Calhoon MEBA Engineering School count for purposes of determining your eligibility for Medical Plan benefits (unless you are otherwise entitled to such credit as work in Covered Employment or unless you are receiving vacation benefits paid by the MEBA Vacation Plan), even if there is no contribution obligation. Days of attendance at the Maritime Institute of Technology & Graduate Studies ("MITAGS") on or after January 1, 2021, count for purposes of determining your eligibility for Medical Plan benefits provided you are a mate and (unless you are otherwise entitled to such credit as work in Covered Employment or unless you are receiving vacation benefits paid by the MEBA Vacation Plan), even if there is not contribution obligation. Notwithstanding anything in this Section to the contrary, for purposes of establishing initial eligibility and maintaining eligibility, "overlap days" count as days on the payroll in Covered Employment. An "overlap day" occurs when an employee who first reports to work aboard a vessel and the employee being relieved are both required to work on, and are paid a shipboard wage for that same day, regardless of whether contributions are paid on behalf of either such employee for that day.

HIPAA Special and Late Enrollment, Mid-Year Status Changes

Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Medical Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment

within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You and/or your dependents may also enroll in this Medical Plan if you or your dependents have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you or your dependents lose eligibility for that coverage or become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends or is determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the Plan Office.

Extending Coverage After Coverage Ends

Under COBRA, you may be eligible to extend coverage for yourself and your dependents following the end of coverage. If you choose to do so, you'll have to pay the full cost of coverage yourself. Details about electing COBRA coverage are provided later in this SPD.

Your Medical Plan coverage continues to the last day of the six month period following the last day of Covered Employment that was used to earn your eligibility. If you become totally disabled, coverage continues for 18 months instead of six months and the following rules apply:

If the disability occurs while actively employed, the 18-month extension will run from the last day of Covered Employment (date of disability).

If the disability occurs while on a vacation period immediately following Covered Employment (for which you filed prior to the disability), the 18-month extension will run from the last day of the vacation period.

If the disability occurs subsequent to the last day of the vacation period immediately following Covered Employment (for which you filed prior to the disability), the 18-month extension will run from the last day of the vacation period that immediately followed Covered Employment.

If you are employed by District No. 1-PCD, MEBA (the "Union"), the Calhoon MEBA Engineering School, the Plan Office, or another employer that covers non-collectively bargained employees, your coverage begins after you complete one month of continuous employment and ends on the last day of the month in which your employment terminates.

In all cases, your coverage ends immediately upon entering military service unless you elect to continue coverage under the Uniformed Services Employment and Re-employment Rights Act ("USERRA").

Dependent Coverage

While you are covered by the Plan your qualified dependents are also covered for medical and dental benefits. Your qualified dependents are:

Your spouse (coverage for your spouse ends on the date of divorce, legal separation or when you and your spouse enter into a written agreement to live separately);

Your natural, adopted children, and stepchildren under the age of 26;

Your unmarried grandchildren under age 26 if they are members of your household and principally dependent on you for support provided that: (1) the Eligible Employee has been awarded long-term legal custody of the grandchild by a court or appropriate state agency; (2) the Eligible Employee has been unable to adopt the grandchild due to circumstances beyond the Employee's control; (3) the Eligible Employee claims the grandchild as a dependent on the Employee's federal income tax return; and (4) both parents of the grandchild are totally disabled, incarcerated or deceased, or are otherwise unable to care for the grandchild;

Children for whom you are obligated to provide medical coverage under a Qualified Medical Child Support Order, subject to the age limits above; and

Your parents, if you do not have a spouse or children who qualify as dependents, and your parents are

principally dependent on you for support and are claimed as dependents on your federal income tax return.

If your dependent is covered by more than one health care plan, the Medical Plan's Coordination of Benefits rules will apply.

The age limits for dependent children do not apply to an unmarried child who is incapable of self-sustaining employment by reason of mental or physical disability, provided the child became incapable before the age limit was reached.

Coverage for your qualified dependents ends when your coverage ends, or when they cease to be qualified dependents as defined above. If you die while covered, coverage for your qualified dependents continues at no cost for five calendar months after the month of your death -- except that surviving spouses are eligible to receive retiree medical benefits until they reach age 65 and become eligible for Medicare (provided that you had a minimum of five years of vesting credit and did not retire before November 1, 2003). Surviving dependent children may receive benefits until they attain the maximum age applicable above. After that coverage ends, your qualified dependents may extend coverage under COBRA, but they will have to pay for it.

It is your obligation to notify the Plan Office in writing within 30 days if your dependents no longer meet any of the above requirements.

Spousal Waiver of Coverage

Your spouse may elect to withdraw from coverage under the Medical Plan subject to the following rules:

- Your spouse must execute before a notary public or Medical Plan employee a written application and election to withdraw from coverage;
- Your spouse must acknowledge in writing that the election to withdraw is voluntary;

- An election to withdraw from coverage can only be revoked in writing before a notary public or a Medical Plan employee;
- Future coverage for your spouse will be effective on the first day of the month following the Medical Plan's receipt of a written revocation to withdraw from coverage.

When Coverage Terminates

If you and/or your dependent no longer meet the Plan's eligibility requirements, your coverage and/or your dependent's coverage will end as provided above. You are required to notify the Plan Office in writing within 30 days of events that affect you and/or your dependent's eligibility under the Plan. The Plan also reserves the right to retroactively rescind or cancel your coverage under the Plan if you or any of your dependents engage in fraud and/or intentional misrepresentation of a material fact, or if you or your Employer fails to timely pay premiums or contributions to the Plan. Failure to follow the terms of the Plan, such as failing to notify the Plan of a change in dependent status, accepting benefits in excess of what is covered under the Plan, or after you or your dependent are no longer eligible for coverage, will be considered fraud and/or intentional misrepresentation. You are treated as having knowledge of all the eligibility terms of this Plan. Events that may lead to ineligibility and a retroactive loss of coverage under the Plan include, but are not limited to:

- Failure to report a divorce;
- Failure to report a legal separation;
- For grandchildren:
  - Failure to report a change in residency;
  - Failure to report a change in support;
  - Failure to report a child's marriage; or
  - Failure to meet the grandchild's eligibility rules

- Failure to timely pay any required premiums (e.g. COBRA, pensioner contributions, Alternate Medical Plan premiums).

If you do not timely notify the Plan Office of an event that causes a loss or change in you or your dependent's eligibility under the Plan, you will be required to reimburse the Plan for benefits that were paid after the event that caused you and/or your dependent's coverage to be terminated.

The Permanent Data Form also collects information the Plan needs to administer other benefits in addition to your medical coverage (e.g., dental coverage, life insurance and accidental death and dismemberment insurance).

You Must Submit a Permanent Data Form

To have Medical Plan coverage you must submit a Permanent Data Form to the Plan Office in Baltimore, Maryland. Your dependents' coverage will begin at the same time as your coverage or as soon as a dependent becomes qualified, whichever occurs later.

Your qualified dependents are not covered under the Medical Plan unless a Permanent Data Form has been completed, signed and submitted to the Plan Office and they are listed on the Permanent Data Form. If there is any change to your dependents' status (e.g., birth, death, etc.), you need to submit a new Permanent Data Form.

A PPO is a network of doctors, hospitals, and other health care professionals and facilities that have agreed to charge discounted rates for their services. We call them "preferred providers." The PPO network used by the Plan is provided through CareFirst BlueCross BlueShield. You may obtain a list of preferred providers by visiting their website at www.bcbs.com. "Allowable" charge means the lowest of: (a) the usual charge of the provider for the service or supply (in the absence of the coverage provided

In Network and Out of Network Coverage

If you use a PPO preferred provider, you have to pay a $20 co-payment each time you visit a doctor or hospital. The Medical Plan pays 90% of your covered expenses charged by a hospital and 80% for medical and mental health charges, after applicable co-payments.

If you use a provider who does not participate in the PPO network, you'll still receive benefits, but you may have to pay more out of your own pocket. After you pay an annual deductible for inpatient hospitalization ($250 per person/$500 per family per calendar year), the Plan generally pays 60% of the allowable charge for the hospitalization and you pay the rest (subject to an out-of-pocket limit). For non-hospital expenses, there is no deductible and the Plan generally pays 60% of the allowable charge for covered expenses and you pay the rest (subject to an out-of-pocket limit). If you use a non-PPO provider, your provider's charges may exceed the

under the Plan), but not more than the prevailing charge in the geographic area for the same or similar 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.

There are several advantages to using a PPO provider for covered expenses:

Lower costs wind up saving both you and the Plan money, and

You don't have to pay any charges above the allowable charge.

Simply show your CareFirst BlueCross BlueShield card (which you'll receive when you begin Plan coverage).

"Covered expenses" means the types of medical services and supplies covered by the Medical Plan. The services and supplies must be performed or prescribed by a qualified provider and, except for

allowable charge. In that case, the Plan pays benefits based only on the allowable charge and you pay any amounts the Plan doesn't pay.

No Surprises Act Services received by an Eligible Employee will be covered subject to the Plan's participating PPO applicable Cost Sharing.

Even when a non-PPO provider is used, the Plan's payment will be 80% of the allowable medical charges where a good faith effort is made to use a PPO provider.

Please note that, regardless of whether your doctor or hospital is a PPO preferred provider:

- You are required to get precertification before you are admitted to the hospital except for certain cases of emergency as described in Appendix B;
- You are required to get precertification before having any non-emergency outpatient surgery;
- You are required to get precertification for varicose vein surgery and Botox or other similar treatment; and

specifically covered preventive care, must be medically necessary for the treatment of an illness or injury.

Please see “Covered Expenses for Active Employees” and the “Summary of Benefits” chart for more information about covered expenses.

- The Plan only pays for covered expenses.

These requirements are explained in greater detail later in this section.

How the Deductible Works

Once an individual reaches his or her individual $250 deductible, the deductible is considered satisfied for that individual for the remainder of the calendar year. Once any combination of covered individuals reaches the $500 family deductible, the deductible is considered satisfied for all covered family members for the remainder of the calendar year. After the deductible is satisfied, the Medical Plan pays the amounts set forth above.

“Out-of-pocket costs” means co-pays, the 10% (PPO) or 40% (non-PPO) of covered hospital expenses, and the 20% (PPO) or 40% (non-PPO) of covered non-hospital expenses you must pay, plus any annual deductible, and 20% of covered prescription expenses. Out-of-pocket costs do not include non-covered expenses, charges in excess of the allowable charge, or penalties for failure to get a required pre-certification, as explained below.

Out-of-Pocket Limit

If you and your qualified dependents incur $3,500 in "out-of-pocket costs" for covered medical expenses in a calendar year, the Plan will pay 100% of the allowable charge for covered medical expenses for your family for the remainder of that calendar year.

If you and your qualified dependents incur $1,500 in "out-of-pocket costs" for covered prescription drug expenses in a calendar year, the Plan will pay 100% of the allowable charge for covered prescription drug expenses for your family for the remainder of that calendar year.

Precertification Requirements

Except for certain cases of emergency as described in Appendix B, the Medical Plan requires you to get precertification of an inpatient hospitalization and any outpatient surgery before surgery is performed. These requirements apply to both PPO and non-PPO providers, and it is your responsibility to get any required precertification.

Precertification of Hospitalization

Except for certain cases of emergency as described in Appendix B, you must obtain precertification of you (or your dependent’s) admission to a hospital. This precertification is intended to help you and your

qualified dependents make informed decisions when facing hospitalization.

If you have any questions about whether a particular treatment or service is covered under the Medical Plan, contact the Plan Office in Baltimore in writing.

If a doctor recommends that you stay overnight in a hospital, simply contact American Health Holdings (AHH) prior to your non-emergency admission, or as soon as possible following an emergency admission, by calling AHH's toll free number 1-800-641-5566.

If a non-emergency hospital admission is not precertified, the charges associated with the admission will not be covered. You will be responsible for paying the hospital room and board charges and charges for any services and supplies in connection with the hospital admission, and they won't count toward either the deductible or the Out-of-Pocket Limit.

Precertification of Outpatient Surgery

You must precertify you (or your dependent's) non-emergency outpatient surgery. Remember, the Medical Plan only covers procedures and treatment that are medically necessary. This precertification is intended to ensure that the outpatient surgery is medically necessary prior to your incurring the cost of the procedure. If a doctor recommends that you have outpatient surgery, contact American Health Holdings (AHH) prior to scheduling your surgery by calling AHH's toll free number 1-800-641-5566.

If you don't get your non-emergency outpatient surgery pre-certified, you will be responsible for paying the expenses in connection with your surgery, and they won't count toward either the deductible or the Out-of-Pocket Limit.

Precertification of Other Services

American Health Holdings offers additional services that will help you or your dependents (1) manage claims dollars, (2) decide on the best treatment plan, and (3) facilitate the payment of claims. Precertification of the following services is NOT mandatory, but is available should you or your dependents choose:

- Outpatient treatment for substance/alcohol abuse
- Outpatient continuing care services which include:
  - Durable medical equipment and prosthetics or braces when cost of such items exceeds $500;
  - Home health care;
  - Speech therapy; and
  - Physical and occupational therapy when necessitated by stroke, multiple sclerosis or radical mastectomy.

No Surprises Act

The No Surprises Act protects patients from certain balance billing charges by out of network providers under specific circumstances. See Appendix B for details on the No Surprises Act requirements.

Licensed Qualified Provider

Except as specifically stated otherwise in this SPD or the Rules and Regulations, the Medical Plan only covers services provided by a Licensed Qualified Provider. A Licensed Qualified Provider is a person who is duly licensed to:

- prescribe and administer any drugs,
- perform surgical procedures,
- perform chiropractic manipulations,
- who is a certified nurse midwife or certified registered nurse anesthetist,
- 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 or she practices, or
- with respect to alcohol, drug and other substance abuse benefits, is a certified substance professional, as defined in the Plan's Rules and Regulations.

A licensed nurse practitioner, or licensed physician's assistant, is deemed to be a Licensed Qualified Provider when acting within the scope of his or her license. Also, physiotherapy performed under the supervision of a Licensed Qualified Provider is covered (but subject to maximum visit limits). For purposes of vision therapy, a duly licensed Doctor of Optometry is considered to be a Licensed Qualified Provider when acting within the scope of his or her license.

Health Care Decisions

You are responsible for making decisions regarding the coverage option you choose and for your selection of physicians and other medical providers. In addition, you and your physician are responsible for choosing the course of treatment for (or for choosing not to treat) any illness, injury or other medical condition. The Trustees and/or your employer are not in any way responsible for the outcome of any medical treatment or health care (or lack of such treatment or care).

Covered Expenses for Active Employees

The following is a brief summary of covered expenses.

Hospital Room and Board

The Medical Plan covers charges for a semi-private room. Additional charges for a private room are covered only if shown to be medically necessary

Hospital Services and Supplies

The Medical Plan covers services and supplies furnished in a hospital in which the covered individual is confined.

Outpatient Hospital-Type Services

The Medical Plan covers outpatient hospital-type services related to surgical procedures performed at an approved ambulatory surgical center.

Physician and Surgical Charges

The Medical Plan covers physician and surgical charges for services rendered by a Licensed Qualified Provider.

Nursing Care

The Medical Plan covers private duty nursing care by a Registered Nurse (RN), or, if an RN is unavailable, by a Licensed Practical Nurse (LPN), provided in a hospital in which the covered individual is confined. The Plan also covers private duty nursing care by an RN or LPN provided in a setting other than a hospital during the first 30 days following discharge from a hospital (but not more than 30 days total coverage in any twelve months). No coverage is provided for nursing care provided by the patient's spouse, brother, sister, children or parents.

Mental and Nervous Disorders

If you or your dependent is confined in a hospital for the care and treatment of a mental or nervous disorder, the Medical Plan will treat that as a covered expense for up to a maximum of three days of treatment per calendar year. Covered charges that exceed the calendar year three-day maximum benefit apply toward your family's $3,500 out-of-pocket maximum for covered medical expenses and $1,500 out-of-pocket maximum for covered prescription drug expenses. Any out-of-pocket expenses covered by the Plan in excess of $3,500 covered medical expenses or $1,500 covered prescription drug expenses within a calendar year are paid at 100% of the discounted or PPO allowed charges (or allowable charges) for the remainder of the calendar year.

Outpatient expenses for the treatment of a mental or nervous disorder provided by a non-PPO provider are covered at 70% of the allowable charges, and outpatient benefits provided by a PPO provider are covered at 90% of the allowable charges.

Alcohol, Drug and Other Substance Abuse

The Medical Plan covers 100% of the allowable charges for the care and treatment of alcoholism and drug and other substance abuse.

Any inpatient hospitalizations for substance/alcohol abuse or mental health treatment are subject to the Plan's precertification requirements. Contact American Health Holdings prior to your non-emergency admission, or as soon as possible following an emergency admission, at 1-800-641-5566.

Maternity Benefit

The Medical Plan covers maternity-related expenses incurred by you or your covered spouse. Maternity expenses of dependent children are not covered, except to the extent required by law.

Newborns' and Mothers' Health Protection Act

In accordance with Federal law, the Medical Plan does not restrict benefits for any covered hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Influenza Vaccination Benefit

The Medical Plan covers one annual influenza vaccination.

Well-Baby Visits Benefits

The Medical Plan covers well-baby visits for a newborn baby while in the hospital immediately following birth through discharge of the mother from the hospital.

The Plan also covers services rendered to a newborn baby while in the hospital immediately following birth

through discharge; provided such services are required by state, local or federal statute.

Optical Expense Benefit

For eligible employees, their spouses and covered dependent children age 19 or older, the Medical Plan pays up to a total of $180 per calendar year for the following optical services and supplies:

- Optical examination by an ophthalmologist or optometrist;
- Prescription eyeglasses, including frames; and
- Contact lenses.

If you do not use all of your annual benefit during a calendar year, the balance may be carried over for two additional calendar years, up to a maximum three-year benefit of $540.

For covered dependent children under age 19, the Plan covers 100% of allowable charges for optical services limited to one exam and one pair of glasses (lenses and frames) or contact lenses per calendar year.

Hearing Aid Benefit

During any three (3) consecutive calendar year period, the Medical Plan pays (a) 80% of charges incurred up to a maximum of $3,000 for hearing aid instrument(s); (b) the first $75 of the sum of all charges for hearing related examination(s), every two (2) calendar years. You are responsible for paying the remaining amount. (When filing a claim, you must include a recommendation for a hearing aid from a Licensed Qualified Provider.) For dependents younger than 19, the Medical Plan will pay 80% of charges up to a maximum of $75 for a hearing related examination every calendar year.

Prescription Drug Benefit

There are several advantages to using OptumRx, in addition

OptumRx is the Medical Plan's prescription drug benefit administrator. OptumRx's network includes participating pharmacies in the U.S. As a participant, you should

to lowering your drug costs:

- Because the total cost of the drug is typically significantly reduced, your 20% co-pay is typically significantly reduced as well;
- You pay only your 20% co-pay at the time you get your prescription and no longer have to wait for the Medical Plan to reimburse you for the remaining 80%;
- You don't have to pay any charges above the allowable charge; and
- There are no claim forms to complete. Simply show your OptumRx card (which you'll receive when you begin Medical Plan coverage) when you visit a participating pharmacy.

have an OptumRx ID card. If you do not have one, please contact the Plan Office.

In general, the Plan pays 80% of the allowable charge for your prescription drugs and you pay the remaining 20% plus any amount above the allowable charge. The Plan will pay 100% of the costs of certain over-the-counter drugs prescribed by your doctor. The prescription drug benefit does not cover mineral and vitamin supplements, food additives and drugs to stop smoking.

OptumRx has negotiated price reductions with pharmacies to provide quality, low-cost drug coverage. You should use an OptumRx-contracted pharmacy to get maximum prescription benefits under the Medical Plan. Because of the tens of thousands of participating pharmacies and availability of prescriptions by mail order, you and your family should have ready access to OptumRx pharmacies. If you do not use an OptumRx-contracted pharmacy or mail order service, your prescriptions still will be reimbursed by OptumRx, but the amount of reimbursement will be limited to 80% of the allowable charge for the prescription drug.

Regardless of whether or not you use an OptumRx participating pharmacy, the Medical Plan generally does not cover more than a 34-day supply of prescription drugs, except that a 90-day supply may be available by mail order, and a 180-day supply of maintenance drugs for an employee may be covered for sailing employees. With respect to pensioners, non-collectively bargained employees, and dependents, the maximum quantity for all drugs is 34 days (or 90-days through mail order).

The Trustees have implemented the following prescription drug and medicine programs:

Step Therapy

The Plan covers certain prescription drugs and medicines (as determined from time to time by the Trustees) subject to step therapy requirements, under which preferred drug(s) or medicine(s) must be used before receiving authorization for coverage of a non-preferred drug or medicine. Please contact OptumRx for more information about the step therapy program

and the drugs and medicines subject to the requirement.

Member Pays the Difference Program

If you or your qualified dependent elects to receive a brand-name drug, you or your dependent 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 not to 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 Limit described above.

Pharmacogenomics Prior Authorization Program

The Plan covers certain specialty prescription drugs, provided prior authorization is obtained. Ask your doctor to call OptumRx to obtain prior authorization.

Non-Essential Prior Authorization Program

The Plan covers certain non-essential prescription drugs, provided prior authorization is obtained. Ask your doctor to call OptumRx to obtain prior authorization.

Over-the-Counter Medications

The Plan covers certain over-the-counter medications that previously required a prescription, provided that such over-the-counter medication is prescribed by a Licensed Qualified Provider. The Plan pays 100% of the cost for such over-the-counter medications.

If you or your dependent elect to receive a brand-name over-the-counter medication, you or your dependent 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 not to be therapeutically equivalent. The Plan will pay 100% of the lesser of the cost of the brand-named over-the-counter medication and the equivalent generic drug for such over-the-counter medications. 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 Limit described above.

Acupuncturists

The Medical Plan covers medically necessary services provided by licensed acupuncturists acting within the scope of their licenses up to a maximum of 10 visits per person per calendar year. (The limit on visits does not apply to acupuncture treatment by a Licensed Qualified Provider.)

Gynecological Benefits

The Medical Plan covers 100% of allowable charges for one annual routine gynecological examination, including pap smears and related tests.

Mammograms

The Medical Plan covers 100% of allowable charges for one baseline mammogram for women age 35 - 39, and annual routine mammogram for women age 40 and older.

Mammograms performed because of the appearance of symptoms of breast disease are covered under the Plan at 80% (PPO) or 60% (non-PPO) of allowable charges, at any age.

Women's Health and Cancer Rights Act (WHCRA)

Mastectomy/Mammoplasty

In accordance with Federal law, the Medical Plan covers the following medical services in connection with coverage for a mastectomy:

- all stages of reconstruction of the breast on which the mastectomy has been performed**;**
- surgery and reconstruction of the other breast to produce symmetrical appearance;
- prostheses; and
- treatment of physical complications of all stages of mastectomy, including lymphedema.

Orthotics

The Medical Plan covers orthotics up to a lifetime family maximum of $500 (the lifetime maximum does not apply when orthotics are determined to be Medically Necessary and payable under the Durable Medical Equipment Covered Medical Expense).

Hospice Care

When a participant or dependent is terminally ill with cancer, the Medical Plan provides hospice care coverage.

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:

- the service is provided by an eligible practitioner of nutritional counseling, functioning within his or her legal scope of practice, including
  - Medical Doctor (M.D.);
  - Doctor of Osteopathy (D.O.)
  - Registered dietitian or nutritionist licensed by the State Board of Dietetic Practice of that practitioner's location of practice; or
  - 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®. Nutritional counseling beyond twelve (12) visits per condition per year is subject to medical review to determine medical necessity.

Preventive Care Benefits

Immunizations Covered 100% for Adults and Children

The Plan covers immunizations for children and flu shots for adults and children. The Plan also covers immunizations based on the Centers for Disease Control and Prevention (the CDC) recommended guidelines for adults age 19 and older. The cost for the following immunizations are covered in full:

Children under 19 years of age

- Recommended immunizations, including covid vaccines, and flu shots when they are administered by either in- or out-of-network providers.

Adults age 19 and over

- Flu and covid vaccines covered when they are administered by either in- or out-of-network providers
- Td/Tdap, Shingles, Pneumococcal, Meningococcal, MMR, HPV, Chickenpox, Hepatitis A and B covered when they are administered by in-network providers only.

Preventive Office Visits Covered 100% for Children Under 19

Annual physicals and well-baby and well-child preventive office visits are an important way to monitor your child's health and catch problems early. The Plan will cover preventive care office visits for children under 19 years of age 100% when performed by an in-network provider. The preventive care office visits will be covered as follows:

- One visit three to five days after birth;
- One visit each at 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months; and

- One visit each year beginning at age 3 through age 18.

Covered services during well visits include a physical exam, administration of necessary immunizations, tracking growth, a developmental/behavioral/learning assessment and discussion on illness prevention, diet, physical fitness, and health and safety issues, among other services and will be based on the judgment of your physician, subject to the Plan's general exclusions.

Colonoscopies and Cologuard Colorectal Cancer Screening Covered 100%

According to the American Cancer Society, preventing colorectal cancer (and not just finding it early) is a major reason for getting tested. Finding and removing polyps can help prevent some people from getting colorectal cancer. For that reason, the Plan covers 100% of the expense of routine colonoscopies or Cologuard colorectal cancer screening tests performed by a CareFirst PPO Provider for participants and their covered dependents once every three years as follows:

- At age 45 and older; or
- Younger if you are at increased risk due to family history (beginning at the earlier of age 40 or 10 years before the youngest age that an immediate relative (i.e., a parent or sibling) was diagnosed with colorectal cancer.

Other Preventive Screenings and Tests Covered 100%

Preventive screenings and tests can help with the early detection of cancers, as well as changes in the status of existing conditions. The Plan covers the following tests and screenings 100% when they are administered by in-network providers:

Disease	Benefit	In-Network Coverage	Limitations
Diabetes	Annual Hemoglobin A1C Test	100%, covered only with a related diagnosis	One test per year for diagnosed diabetics
	Annual Diabetic Nephropathy Screening	100%, covered only with a related diagnosis	One test per year for diagnosed diabetics
	Annual Diabetic Retinopathy Screening	100%, covered only with a related diagnosis	One test per year for diagnosed diabetics
Hyperlipidemia	Total Cholesterol Testing	100%, covered only with a related diagnosis	
COPD (Chronic Obstructive Pulmonary Disease)	Spirometry Testing	100%, covered only with a related diagnosis	
Cancer	Cervical Center Screening	100%	One annual routine gynecological exam, including a PAP smear
	Breast Cancer Screening	100%	One baseline mammogram for women age 35-39; one mammogram per year for women 40 years of age and older

Dependent Contraceptives

The Plan covers contraceptives for dependent children, subject to the existing cost sharing and coverage rules of the Plan.

Under the Plan's coverage rules, the Plan will not cover certain contraceptives, including the following:

- Spermicide, jelly, cream
- Surgical sterilization
- Condoms
- Foam
- Sponge

Please note that this list is not all inclusive.

“Durable medical equipment” means 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, (4) generally are not useful to a person in the absence of an illness or injury, and (5) 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 the Plan.

Charges for Other Services and Supplies

The Medical Plan covers charges for the following services and supplies made in connection with an illness or injury if medically necessary and prescribed by a Licensed Qualified Provider:

- X-rays and lab examinations;
- Anesthetics (including administration);
- Oxygen (including administration);
- Rental (or purchase, when cost effective) of durable medical equipment;
- Chiropractic treatment, x-ray or physical therapy or other similar therapeutic treatment performed by or under the supervision of a Licensed Qualified Provider. Chiropractic treatment and physical therapy are limited to 80 visits per person in a two-year period combined, and prior authorization is required for more than 40 combined chiropractic treatment and physical therapy visits in a two-year period. This limit does not apply for physical therapy treatment following a stroke, radical mastectomy, or if used as treatment for multiple sclerosis or a condition caused by multiple sclerosis; No prior authorization or maximum visit limitations apply to any physiotherapy or physical therapy treatment for a mental health condition or substance abuse disorder.
- Local use of an ambulance when medically necessary for transportation to the nearest facility equipped to provide treatment. Local use of non-PPO air ambulance services that are Medically Necessary is a No Surprises Service subject to the Medical Plan’s applicable PPO Cost Sharing.
- Speech therapy by a qualified speech-language pathologist, provided the speech impairment is caused by injury or disease. In the case of a congenital defect, speech therapy expenses will be covered provided corrective surgery for the defect either has been performed or is not appropriate.
- Blood and blood plasma (including administration);
- Prosthetics, braces or crutches when made necessary by an illness or injury;
    - Vision therapy prescribed by and performed by and performed under the supervision of a Licensed Qualified Provider.

- Hematopoietic cell transplants for the treatment of Crohn’s disease, when provided as part of a Phase II clinical trial.

- Medically necessary screening, diagnosis and treatment of Autism Spectrum Disorders. These treatments may include necessary assessments, evaluations and testing to determine whether an individual has one or more Autism Spectrum Disorders. "Autism Spectrum Disorders" means a range of conditions characterized by challenges or deficits with social skills, repetitive behaviors, speech and nonverbal communications, as well as by unique strengths and differences caused by different combinations of genetic and environmental influences.
- Behavioral health treatments such as professional, counseling, guidance services and treatment programs, including Applied Behavioral Analysis (ABA) when provided by a Licensed Qualified Provider. "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.
- Occupational therapy prescribed and performed by a Licensed Qualified Provider, not to exceed 30 visits per year when combined with physical therapy visits, provided no maximum visit limit applies to occupational therapy treatment of a mental health condition or substance abuse disorder.
- SARs-CoV-2 and COVID-19 diagnostic testing, and items and services furnished to the eligible employee or dependent during healthcare provider visits (including in-person visits and telemedicine visits), urgent care center visits, and emergency room visits to obtain such testing, to the same extent as covered diagnostic testing but excluding over the counter tests.
- Coronavirus preventive services, provided the item, service, or immunization has been approved by the United States Preventive Services Task Force (USPSTF), as specified in the Rules and Regulations, or recommended by the Advisory Committee on

Immunization Practices of the Centers for Disease Control and Prevention (CDC).

- Covered medical services provided by a PPO provider by telephone conference or video conference, subject to any applicable Plan rules and cost-sharing requirements that would apply to an in-person visit for the same service.
- If necessary to treat non-intractable chronic migraine, the Medical Plan will cover occipital nerve decompression surgery, bilateral occipital neurectomy and ablative treatments of occipital neuralgia for eligible employees (and their dependents), up to a maximum payment of seven thousand dollars ($7,000).

Gene Therapy

Gene Therapy means a medically necessary nonexperimental technique approved by the Food and Drug Administration (FDA) that uses human genes to treat or prevent diseases, as defined in the Rules and Regulations. Non-human gene therapy does not constitute Gene Therapy and will not be covered.

If an eligible employee or dependent 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").

Bariatric Procedures

Expenses incurred by an active employee (including an administrative staff employee) in connection with an FDA approved bariatric procedure for the treatment of obesity are covered by the Medical Plan's provisions for hospital, surgical and medical benefits, subject to the satisfaction of the following criteria: the active 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 (1) one structured diet program for six consecutive months or (2) two structured diet programs for three consecutive months; and (v) the Covered Medical Expenses must be incurred through a Preferred Provider Organization. Coverage of expenses associated with FDA approved bariatric procedures are not available to dependents of active employees, pensioners or dependents of pensioners.

Gender Dysphoria

If an active employee, pensioner or dependent of an active employee or pensioner incurs Covered Medical Expenses in connection with treatment of gender dysphoria, including but not limited to gender reassignment surgery, such charges will be payable in accordance with the Plan's provisions for the payment of hospital, surgical, and medical benefits. Like all non-emergency surgery, precertification is required for gender reassignment surgery.

Annual Physicals

You and your qualified dependents are entitled to one annual health examination (physical) each calendar year. Prior to July 1, 2025, physicals were available at a MEBA Diagnostic Center, Designated Alternate Clinic, or, on and after January 1, 2024, at an in-network physician of your choosing. Effective July 1, 2025, the MEBA Diagnostic Centers are closed. On and after January 1, 2024 you and your dependents can have your annual physical at an in-network physician of your choosing. Such a physical is covered at 100%.

The Trustees maintain a Travel Policy. Reimbursement for travel to a MEBA Diagnostic Center for appointments on and before June 30, 2025, were made in accordance with the Travel Policy, which is attached as Appendix A to this SPD. Different rules apply for travel to a Designated Alternate Clinic (described below).

ALTERNATE GULF COAST CLINIC SITES

Prior to July 1, 2025, in addition to the Diagnostic Centers and the option to use an in-network physician of your choice, two Gulf Coast clinic sites were available at which employees, pensioners, and qualified dependents living in the Gulf Region could receive their annual physicals. The clinics were located in the Houston and New Orleans areas. The Plan does not reimburse for services provided at the alternate clinics after June 30, 2025.

HOUSTON

American Family Care Urgent Care
7322 Southwest Freeway Suite #471
Houston, TX 77074
Telephone: (713) 636-9927

NEW ORLEANS

West Jefferson Industrial Medicine, L.L.C.
107 Wall Boulevard, Suite A
Gretna, LA 70058
Telephone: (504) 433-5070

It was not mandatory that employees and pensioners living in the Gulf Region and their dependents use these alternate clinic sites.

SERVICES

Prior to July 1, 2025, the following services were available from the alternate clinics and the MEBA Diagnostic Centers:

	MEBA Diagnostic Centers Baltimore or Oakland	American Family Care Urgent Care	West Jefferson
Annual Physical	Yes	Yes	Yes
Completion of required Coast Guard forms (Eligible Employees)	Yes	Yes	Yes
Completion of required MSC forms (Eligible Employees)	Yes	Yes	Yes
Completion of required School forms (Dependent Children)	Yes	Yes	Yes

Verification of Annual Examination	Yes	Yes	Yes
Benzene Certification	Yes — results sent to and certificate issued by the Plan Office in Baltimore.	Yes — results sent to and certificate issued by the Plan Office in Baltimore.	Yes — results sent to and certificate issued by the Plan Office in Baltimore.
PPD	Only if Participant can return within 3-4 days to have results read.	Only if Participant can return within 3-4 days to have results read.	Only if Participant can return within 3-4 days to have results read.

PRE-EMPLOYMENT PHYSICALS

Pre-employment physicals were not available at the Designated Alternate Clinic sites, however the reports issued by the Designated Alternative Clinics would contain on the last page a “fit-for-duty” or “not-fit-for-duty” certification as of the date of the diagnostic examination.

Effective June, 2025, The Medical Plan has entered into an agreement with Concentra, a large national provider of employment physicals to permit active and retired sailing participants who are eligible for medical benefits under the Plan to obtain, once a year, a United States Coast Guard physical exam (with or without benzyne labs) at a Concentra location.

There will be no out-of-pocket cost to the participant for these USCG physicals (with or without benzene labs) provided at a Concentra facility. No preauthorization is required for the USCG exam without benzene labs; pre-authorization is required for the USCG exam with benzene labs. Contact the Plan Office for information on how to obtain pre-authorization. Concentra will bill the Medical Plan directly for these exams. Concentra doctors will complete and sign the USCG-required medical form (CG Form 719K) and benzene certificates.

Concentra’s forms will verify if you are “fit-for-duty” but Concentra does not automatically provide a fit-for-duty” or “not-fit-for-duty” certification as was provided by the Diagnostic Centers. However, if you contact the Plan Office in Baltimore and obtain the form that was previously

used, Concentra will complete it for you in connection with your USCG exam.

Concentra physicals do not take the place of a complete physical. The Medical Plan will continue to cover the full cost of one annual physical with an in-network provider in addition to the one annual Concentra physical (with or without benzene labs). Out-of-network providers are subject to deductibles and co-pays.

Generally, you must be eligible to participate in the Plan and be an active or retired sailing participant to have the Plan cover a Concentra physical. However, one annual physical exam per lifetime is provided for an individual who is not an eligible employee or dependent, but is a registered individual seeking employment with an Employer. To be considered a registered individual for this once a lifetime physical, the potential Employer must contact the Union on your behalf.

FREQUENCY OF EXAM

Regardless of whether an in-network or out-of-network provider is used, you and your dependents are entitled to an annual diagnostic examination not more than once in any calendar year.

However, as noted above, active and retired sailing participants are entitled to one Concentra USCG physical and one diagnostic examination each calendar year.

ELIGIBILITY

In order to receive an annual diagnostic examination, you must meet the eligibility requirements for benefits under the Plan. Prior to July 1, 2025, the Plan also provided one annual physical exam per lifetime for an individual who is not an eligible employee or dependent, but is a registered individual seeking employment with an Employer. On and after July 1, 2025, a registered individual may obtain the one pre-employment exam at a Concentra location (see discussion above).

No transportation costs associated with this exam are covered.

In order for a pensioner to receive an annual diagnostic examination, the pensioner must make the required pensioner contributions to the Plan.

TRANSPORTATION

Prior to July 1, 2025, if one of the alternate Gulf Coast clinics was used and your Home of Record is in excess of 75 miles from the alternate Gulf Coast clinic, an allowance of $50 per family was payable, provided transportation receipts were provided. No other transportation benefits were payable when an alternate Gulf Coast clinic was used.

Note: Anyone living outside the 75-mile limit was eligible to be reimbursed the $50 only when an alternate Gulf Coast clinic was used.

Summary of Benefits for Active Employees

This chart provides a convenient summary of your medical coverage under the Plan; exceptions for out-of-network services may exist if your claim constitutes a No Surprises Service - please see Appendix B for additional information:

Plan Feature	Benefit	
Calendar Year Deductible for Inpatient Hospital Expenses	$250 per individual $500 per family	
Calendar Year Catastrophic Protection Out-of-Pocket Limit	$3,500 per family for Covered Medical Expenses $1,500 per family for prescription drug expenses	
Doctor's Office Services		
	PPO	**Non-PPO**
Office Visits	Plan pays 80% after you pay $20	Plan pays 60% of allowable charges and you pay the rest
X-Ray and Lab Tests	Plan pays 80%	Plan pays 60% of allowable charges and you pay the rest
Hospital Inpatient Services (subject to Precertification Requirements)		
	PPO	**Non-PPO**
Room and Board (up to semi-private room rate), Inpatient Facility Charges (including intensive care) and related lab and x-ray charges	Plan pays 90%	After deductible, Plan pays 60% of allowable charges and you pay the rest
Anesthesia, Physician Consultations, Surgical Services	Plan pays 80%	Plan pays 60% of allowable charges and you pay the rest
Hospital Outpatient Services		
	PPO	**Non-PPO**
Necessary Emergency Room Treatment for Illness or Accidental Injury	Plan pays 80% after you pay $20	Plan pays 80% after you pay $20
Ambulatory Surgery Centers (facility fee, related lab and x-ray)	Plan pays 90%	After deductible, Plan pays 60% of allowable charges and you pay the rest
Anesthesia, Physician Consultations, Surgical Services	Plan pays 80%	Plan pays 60% of allowable charges and you pay the rest

Plan Feature	Benefit	
Inpatient Psychiatric Care		
	PPO	**Non-PPO**
Inpatient Treatment of Mental and Nervous Disorders	Plan pays 90% for the first 3 days of care. You pay 100% of charges until you reach $3,500. Once $3,500 is met, the Plan pays 100% of charges.	Plan pays 60% of allowable charges for the first 3 days of care. You pay 100% of charges until you reach $3,500. Once $3,500 is met, the Plan pays 100% of charges.
Outpatient Psychiatric Care		
Outpatient Treatment of Mental and Nervous Disorders	Office visits: Plan pays 80% after you pay $20 Other outpatient services (partial hospitalization, intensive outpatient): Plan pays 90%	
Alcoholism And Drug-Abuse Care		
Alcohol, Drug and other Substance Abuse	Plan pays 100% of allowable charges	
Other		
Annual Physical Exam by appointment at a MEBA Diagnostic Center (on or prior to June 30, 2025), Designated Alternate Clinic, or in-network physician	Once in a calendar year. On or prior to June 30, 2025. transportation benefits are also payable for active employees and their qualified dependents who live in excess of 75 miles from the MEBA Diagnostic Center nearest their Home of Record. Travel allowance up to $50 for Alternate Clinics. No travel paid for other physician.	
Optical Care	Plan generally pays up to $180/calendar year for each covered individual. If you do not use all of your annual benefit during a calendar year, the balance may be carried over for two additional calendar years, up to a maximum three-year benefit of $540.	
Hearing Aids	During any three consecutive calendar year period, the Plan pays: ▪ 80% of charges incurred up to $3,000 for hearing aid instrument(s) and you pay the rest; plus ▪ 80% of charges incurred up to $75 for hearing related examination(s) and you pay the rest. For dependents younger than 19, the Medical Plan will pay 80% of charges up to	

Plan Feature	Benefit
	a maximum of $75 for a hearing related examination every calendar year.
Prescription Drugs	Plan pays 80% of scheduled charges and you pay the rest. Plan pays 100% of the costs of certain over-the-counter drugs prescribed by your doctor.
Pre-Employment Drug Test	No more frequently than once every six (6) months for employees: (a) who have worked in covered employment for at least 60 days in the six-month period immediately preceding the pre-employment drug test and (b) whose employer is subject to the governmental drug and alcohol testing regulations. If you are a new entrant (as defined in Article I of the Rules and Regulations), you will become eligible for a pre-employment drug test after 30 days of covered employment within any period of six consecutive calendar months. If you are a new entrant or a pensioner who is returning to work with the permission of the Trustees, you must pay a fee in order to receive a Pre-Employment Drug Test.

Shipboard Illnesses and Injuries

It's your responsibility to file a report with the appropriate Officer aboard the Vessel. Make sure you get a copy of the report for your records. Failure to file a report may result in denial of coverage by the Plan and your Employer.

Exclusions

No benefits are payable by the Plan for the following:

- Shipboard illnesses and injuries (your Employer is required to pay all such expenses directly);
- Charges for which you or your dependent would be entitled to coverage under any workers' compensation law, or which are incurred in connection with any injury or illness arising out of any employment for wage or profit;
- General health exams, well baby care, immunizations or inoculations, except as specifically provided elsewhere in this SPD;
- Charges above the "allowable" charge for a service or supply;
- Charges related to any organ transplants other than transplants of corneas, kidneys, liver, skin, bone marrow or blood;
- Services or supplies not included in the list of Covered Expenses set forth in the Rules and Regulations;
- Eye examination, eyeglasses and hearing aids except when required as a direct result of an accidental injury to natural eyes or ears, or as described above (see "Optical Benefits" and "Hearing Aid Benefits");
- Orthodontia or other Dental work or treatment except when required as a direct result of an accidental injury to natural teeth or when a dependent of eight (8) years or younger must undergo dental procedures that cannot be performed safely in a dental office setting as described below. (see "Dental Benefits");
- Cosmetic treatment or surgery of any kind, except when necessitated by an accidental bodily injury, and drugs used for cosmetic purposes;
- Charges for non-emergency surgery that is not precertified by American Health Holdings;
- Charges for non-emergency hospitalization that is not precertified by American Health Holdings;
- Charges in connection with hospitalization after the length of stay exceeds the number of days pre-certified by the Plan;

- Transportation or travel except for local use of an ambulance as set forth above, or as may be provided in Appendix B;
- Any item that may be listed as a Covered Expense, but which is received:
  - In connection with a pregnancy or pregnancy-related disability for any dependent other than a qualified dependent spouse, except as required by law;
  - As a result of an injury or illness resulting from war, whether declared or undeclared;
  - For services received at federal government expense except as required by law; or
  - 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 or as the result of a medical condition, including mental health and substance use conditions, will not be excluded.
- Charges resulting from a self-inflicted injury, suicide or attempted suicide, except that such charges incurred by a qualified dependent child under age 26 at the time of the injury, etc. are not excluded. This exclusion does not apply to the extent that the self-inflicted injury, suicide or attempted suicide is incurred as the result of a medical condition, including mental illness or substance use disorder, or domestic violence;
- Charges for care, treatment or maintenance received after the sick or injured person has been cured, or after the illness or incapacity has been declared permanent and/or not responsive to further treatment;
- Charges in connection with artificial fertilization or insemination, including (but not limited to) in vitro fertilization or GIFT procedures;
- Orthotics, except when used as braces or as set forth above;
- Charges incurred in connection with reverse tubal ligation and vasovasostomy;
- Charges incurred in connection with surgical procedures performed for the treatment of obesity, except as described under Covered Expenses;

- Oral medications for impotence if the prescribed dosage exceeds six doses per month;
- Unauthorized prescription refills and lost prescriptions;
- Charges for services and supplies in connection with temporal mandibular joint (TMJ) disorder in excess of a $1,500 lifetime maximum benefit;
- Acupuncture, except when performed by a Licensed Qualified Provider, or when performed by a licensed acupuncturist subject to the limits set forth above;
- Hospital services and supplies which are personal convenience items, such as telephone and television;
- Charges related to the educational or vocational training of the patient; and
- 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. The FDA does not verify the quality, safety and/or effectiveness of compound medications.

Experimental Treatments

The Plan does not cover any treatment, medical device or drug that is either not Medically Necessary or that is Experimental, Educational or Investigative treatments. To the extent needed to satisfy PHSA Section 2709, regarding approved clinical trials, an eligible employee or dependent's participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition will not be denied, and the Plan will not 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. A treatment, medical device or drug will be considered experimental, educational or investigative if:

- 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;

- It is labeled as being for experimental, educational or investigative purposes (or words to that effect);
- 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
- 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.

Medical Necessity

The Plan only covers treatments, medical devices or drugs that are medically necessary. 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:

- Not provided for the diagnosis or direct treatment of an injury or illness;

- Not appropriate and consistent with the symptoms and diagnosis of the patient's injury or illness; or

- Not provided in accord with commonly and customarily recognized medical practice on a national basis.

  Covered expenses do not include charges for services or supplies that are not medically necessary or are not appropriately provided for the treatment of a diagnosed illness or injury.

Coast Guard Legal Aid Benefit

Your U.S. Coast Guard License

If you receive notification of an investigation, complaint or any other action instituted by the U.S. Coast Guard that may adversely affect the status of your U.S. Coast Guard License, you may be entitled to representation by legal counsel provided by the Plan. If you wish to use this benefit, you must contact the Plan Office in Baltimore for a referral to a Plan designated attorney. **THE PLAN WILL NOT HONOR ANY CLAIM FOR PAYMENT OF ATTORNEYS' FEES FROM AN ATTORNEY NOT DESIGNATED BY THE PLAN**. There are specific limitations on this benefit for a

second offense. For more information, see Article XIII-A of the Plan Rules and Regulations.

Wage Insurance Program

Protection for Your Wages

This benefit protects you if you do not receive earned wages because of the bankruptcy or insolvency of the contributing Employer for whom you work. If your Employer is insolvent, bankrupt or otherwise unable to pay your earned wages, the Plan may pay you an amount equal to 90% of your uncollected earned wages (minus required withholding taxes and social security taxes on such amount), provided that the required documents and proof are furnished to the Plan. However, if you continue to work for an Employer after notice from the Plan that wage insurance benefits will not be available after the date of notice, you will not be entitled to benefits from the wage insurance program for wages earned after the date you receive this notice. For additional information as to eligibility for this benefit, see Article XIII of the Plan Rules and Regulations.

Benefits If You Are Medicare Eligible

Active Employees Age 65 and Over and Their Dependents

If you continue to work in Covered Employment beyond age 65, coverage under the Plan will continue for you and your qualified dependents. Because you become Medicare eligible at age 65, you need to know some information about Medicare. Medicare is divided into three key parts -- Part A is hospital insurance, Part B is supplementary medical insurance and Part D is prescription drug insurance. There’s no cost to you for Medicare Part A (provided you apply for it on time -- about three months before you reach age 65). Medicare Part B, on the other hand, requires you to pay a monthly premium. Medicare Part D also requires you to pay a monthly premium. Federal law provides for a penalty if you wait to enroll for Medicare Part B and Medicare Part D until after your 65th birthday, but that penalty can be waived if you are continuously covered under the Plan as your primary coverage.

While you are in Covered Employment with coverage under the Plan, you have the option of enrolling in

Medicare Part A and rejecting Medicare Part B. While you are in Covered Employment, Medicare coverage (Parts A and B) is secondary to the coverage provided by the Plan. However, because Medicare will become your primary coverage when you retire, if you don't enroll in Part B when you are first eligible, there may be a gap between your retirement date and the date your Part B coverage becomes effective. While you are in Covered Employment, you can reject Plan coverage and elect to have Medicare be your sole coverage. To do so, you must notify the Plan Office in Baltimore in writing of your decision. *Think carefully before making this decision. If you make Medicare your sole coverage, the Medical Plan will no longer cover you or your dependents.*

Under Medicare Part D, if you enroll in any Part D Medicare Prescription Plan in any year, prescription coverage under the MEBA Medical Plan will terminate for that year. You will have an opportunity to regain prescription coverage under the MEBA Medical Plan should you terminate the Medicare Part D coverage.

Disabled Employees or Disabled Dependents Under 65

If you are actively employed and you or your qualified dependent(s) are under age 65 and are entitled to Medicare due to disability (other than ESRD), the Plan will pay benefits as primary.

End Stage Renal Disease (ESRD)

If you or your qualified dependent(s) are entitled to Medicare on the basis of age or disability and you become entitled to Medicare based on ESRD, and the Plan is currently paying benefits as primary, the Plan will remain primary for the first 30 months of your entitlement to Medicare due to ESRD. If the Plan is currently paying benefits secondary to Medicare, the Plan will remain secondary upon your entitlement to Medicare due to ESRD.

Medical Coverage for Pensioners and Their Dependents

When You Are a Pensioner

If you're a pensioner, your Plan coverage will be different from the coverage for active employees and

If you retire under the MEBA Pension Trust on or after January 1, 1997, your eligibility for pensioner medical coverage depends on the years of pension credit you have. You must have at least 15 years of pension credit to qualify for pensioner medical coverage under the Plan (unless you retire on a disability pension, in which case you must have at least 10 years of pension credit). The level of benefits available to you and your qualified dependents is also based on the number of years of pension credit you have. One level of benefits is available if you have at least 15 but less than 20 years of pension credit; another level is available if you have at least 20 years of pension credit.

their dependents. The differences take effect on your effective date of pension, not when your active coverage would otherwise run out if you did not choose pensioner medical coverage. Your level of coverage depends on the years of pension credit you earned while working. You must also make contributions toward the cost of medical coverage under the Plan.

You may elect pensioner medical coverage for yourself and your qualified dependents if you waive coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA coverage") or elect COBRA coverage and comply with the Plan requirements with respect to COBRA continuation coverage.

Who Is Eligible

You may choose pensioner medical coverage for you and your qualified dependents if you are entitled to pension benefits from the MEBA Pension Trust (including benefits payable under the MEBA Inland Pension Plan). Pensioners must generally have at least 15 years of pension credit to maintain medical coverage as explained in the margin. (See the Plan Rules and Regulations and the MEBA Pension Trust Regulations for more information.) Pensioner medical coverage under the Plan is only available if you waive COBRA coverage or elect COBRA coverage and comply with the Plan requirements with respect to COBRA continuation coverage.

If your Employer was obligated to contribute to the Medical and Benefits Plan and to the Money Purchase Benefit Plan, but not to the Defined Benefit Plan, for pensioner medical eligibility purposes only, such employment will be treated as though credit was earned under the Defined Benefit Plan.

Special Rule for ROU Pensioners

A pensioner is not eligible for medical coverage under the Plan if he or she earned a majority of his or her pension credit 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. However, such a pensioner is eligible for medical

coverage under the Plan if he or she 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 or her pension credit.

In addition, pension credit earned under an ROU collective bargaining agreement or as an employee of the ROU or the ROU benefit plans is counted only to determine if you have at least 15 (or 10 if disabled) years of pension credit. No ROU earned pension credit is counted to determine if you have at least 20 years of pension credit.

If you fail to pay your pensioner medical contribution on time, your pensioner coverage under the Plan will be permanently cancelled and will not be reinstated.

Dependent Coverage

If you choose pensioner medical coverage at other than the “single” rate, your qualified dependents will be covered as well. “Qualified dependents” has the same meaning as explained earlier for active employee coverage. If a pensioner gets a new dependent as a result of marriage birth, adoption, or placement for adoption after his or her “effective date of retirement” (as defined in the MEBA Pension Trust Rules and Regulations), the pensioner may be able to enroll the new dependent, in accordance with the requirements described under “Dependent Coverage.” However, to add a new dependent child as a result of marriage, birth, adoption, or placement for adoption, the pensioner must request enrollment from the Plan Office in writing within 30 days after the marriage, birth, adoption, or placement for adoption. If the pensioner does not notify the Plan Office within 30 days, then the pensioner cannot add the new dependent child at a later date. Pensioners may add a new spouse at any time.

Cost of Coverage

The monthly pensioner medical contribution for non-Medicare eligible pensioners with dependents is the greater of 6.9% of your gross monthly pension (calculated as a straight life annuity) or $ 575.00. If you took a lump sum pension, you still must pay the above contribution to be eligible. You can choose to drop dependent coverage, in which case your monthly

contribution will be the greater of 6.9% or $345.00. But, if you do so, you will be able to reinstate dependent coverage only once and with proof that other insurance coverage was in place for the dropped dependents during the entire period while not covered by the Plan. Such proof of other coverage must be submitted to the Plan within 30 days of the termination of such other coverage.

Pensioners and their qualified dependents who are covered under Medicare may not utilize the PPO described above for active employees, because providers already have special payment arrangements with Medicare.

The pensioner medical contribution for Medicare eligible pensioners will be 6.45% of your monthly pension (calculated as a straight life annuity) or $107.50, whichever is greater.

If you receive your pension monthly, you can elect to have your medical contributions deducted from your pension check and paid directly to the Plan each month. You also may choose to pay your medical contributions directly. You will be billed quarterly for these contributions, which are due on the first day of each January, April, July, and October.

If you received your pension as a lump-sum distribution, you must pay your medical contributions directly. You will be billed quarterly for these contributions, which are due on the first day of each January, April, July and October. If you choose to elect the direct debit program established by the Plan, your contributions must be deducted on a monthly basis.

If you fail to make your pensioner contribution by the due date, pensioner medical coverage for you and your dependents will be permanently cancelled.

If you receive permission from the Trustees to return to Covered Employment and Employer contributions are made on your behalf, you may request reimbursement of the pensioner medical contributions made to cover those periods of active employment provided:

- You return to active employment and work at least 90 consecutive days in Covered Employment; and
- You made pensioner medical contributions during the period of your active employment.

(Failure to do so results in termination of your Retiree medical coverage under the Plan); and
- You submit an application for reimbursement of your pensioner contributions within twelve (12) months from the last day of Covered Employment.

Once the above requirements have been met, the monthly pensioner medical contributions made will be reimbursed in 30-day increments as follows:

- Return to Covered Employment of 1 day to 89 days, no reimbursement;
- Return to Covered Employment of 90 days to 119 days, reimbursement of one (1) month of pensioner contributions;
- Return to Covered Employment of 120 days to 149 days, reimbursement of two (2) months of pensioner contributions, etc.

When your Covered Employment ends, your active eligibility terminates immediately and you will then revert to the level of pensioner medical benefits under which you were previously covered.

Medicare Part B premiums are not reimbursed by the Plan when your gross monthly pension, calculated as a straight life annuity, is at least $1,000.

Level of Benefits for Pensioners

The level of benefits for which you are eligible as a pensioner depends on the years of pension credit you have and on whether or not you or a qualified dependent are "eligible for Medicare." The Plan considers a person who has reached age 65 to be eligible for Medicare, and to have received reimbursement of all expenses that Medicare would pay, regardless of whether or not the person actually enrolled in Medicare. If your Medicare covered work history is too short to automatically make you eligible for Medicare benefits, you may be able to enroll in Medicare by self-paying for it.

If you have <u>at least 15 but less than 20</u> years of pension credit

*And are **not** eligible for Medicare:*

You and your qualified dependents who are **not** Medicare eligible are entitled to medical benefits from the Plan equal to 60% of the coverage available under

Medicare, subject to annual Plan deductibles ($250 per person/$500 per family) and Medicare deductibles.

*And **are** eligible for Medicare:*

If your gross monthly pension, calculated as a straight life annuity, is **less** than $1,000, and you or any of your qualified dependents **are** eligible for Medicare, you are entitled to reimbursement of the Medicare Part B premiums you paid, but the Medicare eligible person is **not** entitled to medical benefits from the Plan.

Whether or not eligible for Medicare, you and your qualified dependents are not entitled to prescription drug benefits.

Whether or not eligible for Medicare, you and your qualified dependents are entitled to the Hearing Aid benefits described above for active employees.

Pensioners, their spouses, and their dependent children age 19 and older are entitled to Optical benefits in an amount equal to 80% of up to $120 in incurred charges per calendar year (or $96 per year). If you do not use all of your annual benefit during a calendar year, the balance may be carried over for two additional calendar years, up to a maximum three-year benefit of an amount equal to 80% of $360 (or $288).

Covered optical services for a pensioner's covered dependents under age 19 are paid at 80% of allowable charges. Covered services are limited to one exam and one pair of glasses (lenses and frames) or contact lenses per calendar year.

If you have <u>at least 20</u> years of pension credit.

*And are **not** eligible for Medicare:*

You and your qualified dependents who are not Medicare eligible are generally entitled to medical benefits from the Plan. If a PPO provider is used copays are $20. The Plan's payment will be 90% for hospital charges and 80% for medical and mental health charges, after applicable copays, when a PPO provider is used; and 60% if a non-PPO provider is used, subject to annual Plan deductibles ($250 per

person/$500 per family) and the differences noted below.

Benefits for treatment of mental and nervous conditions, alcoholism or substance abuse are different from the level of benefits provided for active employees, as follows:

- PPO outpatient office visits for mental and nervous disorders are covered at 80% of charges, after a $20 copay.
- Other outpatient services for mental and nervous disorders, such as partial hospitalization and intensive outpatient, are covered at 90% of charges.
- All non-PPO outpatient services are covered at 60% of allowable charges.
- Inpatient treatment of mental and nervous conditions, alcoholism or substance abuse is covered at 80% of charges for PPO facilities or 60% of allowable charges for non-PPO facilities..
- Charges for outpatient treatment of alcoholism or drug or substance abuse are not covered.

Pensioners and their dependents are not eligible for the acupuncturist or immunization benefits described under “Covered Expenses for Active Employees.”

*And **are** eligible for Medicare:*

You and any of your qualified dependents who are eligible for coverage under Medicare are covered under a “Medicare carve out” plan. Medicare will be the primary plan and you submit expenses to Medicare first for reimbursement. Once you have received payment from Medicare, submit the expenses to the Plan. After you meet the annual deductible ($250 per person/$500 per family), the Plan will pay 60% of the allowable charges for the covered expenses, reduced by the amount that Medicare paid.

Whether or not eligible for Medicare, you and your qualified dependents are entitled to the Hearing Aid benefits described above for active employees.

Pensioners, their spouses, and their dependent children age 19 and older are entitled to optical benefits in an amount equal to 80% of up to $120 in incurred charges per calendar year (or $96). If you do not use all of your annual benefit during a calendar year, the balance may be carried over for two additional calendar years, up to a maximum three-year benefit of an amount equal to 80% of $360 (or $288).

Covered optical services for a pensioner's covered dependent under age 19 are paid at 100% of allowable charges. Covered services are limited to one exam and one pair of glasses (lenses and frames) or contact lenses per calendar year.

Whether or not eligible for Medicare, you and your qualified dependents are entitled to prescription drug benefits (see the discussion earlier about Medicare Part D).

If your gross monthly pension, calculated as a straight life annuity, is less than $1,000, and you or any of your qualified dependents are eligible for Medicare, you are entitled to reimbursement of the Medicare Part B premiums paid by you.

Dental Benefit

The Plan provides one opportunity for persons with pensioner coverage, including their dependents, to opt into retiree dental benefits.

Out-of-Pocket Limit

If you or a qualified dependent incur $3,500 in "out-of-pocket costs" for covered medical expenses or $1,500 in "out-of-pocket costs" for covered prescription drug expenses in a calendar year, the Plan pays 100% of the allowable charge for all pensioner covered medical or prescription drug expenses for that person for the remainder of that year. Out-of-pocket costs consist of co-pays, the percentage of the allowable charges you must pay, plus any annual deductible. Out-of-pocket costs *do not* include non-covered expenses, charges in excess of the allowable charge, or penalties for failure to get a required precertification.

Termination of Pensioner Benefits

If you return to work in employment in the maritime industry without the written permission of the Trustees of the MEBA Pension Trust ("prohibited employment"), you and your dependents will forfeit eligibility for pensioner medical benefits as follows:

- First Occurrence. If you have not previously engaged in prohibited employment and, upon being notified by the Plan of your engagement in prohibited employment, you take immediate action to suspend such prohibited employment, you will be suspended from eligibility for benefits under the Plan for a period of eighteen (18) months. At the end of the eighteen (18) month suspension period, you will be restored to eligibility for benefits under the Plan, provided you have continued coverage under this Plan during the entire eighteen (18) month suspension period by paying for such coverage at COBRA rates. If you fail to take immediate action to cease such prohibited employment or fail to continue coverage under the Plan during the entire eighteen (18) month suspension period, you and your dependents will immediately and permanently forfeit all eligibility for benefits under the Plan.

- Second Occurrence. If you have previously engaged in prohibited employment and again engage in prohibited employment, you and your dependents will immediately and permanently forfeit all eligibility for benefits under the Plan.

The MEBA Pension Trust – Defined Benefit Plan Summary Plan Description contains a detailed discussion of the penalties that apply to pensioners who work in maritime employment, including an explanation of when such work will be considered prohibited employment.

If you return to work on a vessel in Covered Employment under circumstances that do not constitute prohibited employment, you must continue to make your required pensioner medical contributions for all months in order to keep your pensioner medical coverage. If you work a sufficient number of days on a

vessel in Covered Employment to become eligible for active employee benefits as described earlier in this booklet, you will have active employee coverage (instead of pensioner coverage), but only for so long as you continue to be actively employed on the vessel. You will return to having pensioner medical coverage immediately upon stopping work on the vessel, provided you continued to make your required pensioner contributions.

Pensioner medical coverage for your dependents ends on the last day of the month following the month in which you die. Pensioner coverage for your dependents also ends when they no longer qualify as a dependent as explained above under “Dependent Coverage.” If you die while covered under the Medical Plan, coverage for your qualified dependents may continue, if you had a minimum of five years of vesting credit and did not retire before November 1, 2003. Your surviving spouse is eligible to receive retiree medical benefits until he or she reaches age 65 and becomes eligible for Medicare. Surviving dependent children may receive benefits until they attain age 26. Your dependents may be able to continue their coverage under COBRA as explained below.

If you and/or your dependent no longer meet eligibility requirements, your pensioner medical coverage and/or your dependents’ coverage will end as provided above. You are required to notify the Plan Office in writing within 30 days of events that affect your and/or your dependent’s eligibility under the Plan. Additional events that may lead to ineligibility and a retroactive loss of coverage under the Plan include, but are not limited to:

- Failure to report a divorce;
- Failure to report a legal separation;
- Eligibility for other medical coverage;
- For grandchildren:
  - Failure to report a change in residency;
  - Failure to report a change in support;
  - Failure to report a child’s marriage; or
  - Failure to meet the grandchild’s eligibility rules
- Failure to timely pay any required premiums (e.g. COBRA, pensioner contributions, Alternate Medical Plan premiums); and

- For pensioners, return to work under certain circumstances without the permission of the Trustees.

If you do not timely notify the Plan Office of an event that causes a loss or change in your or your dependent's eligibility under the Plan, you will be required to reimburse the Plan for benefits that were paid after the event that caused your and/or your dependent's coverage to be terminated.

Your pensioner medical coverage or your dependent's coverage under the Plan may also be terminated retroactively in the case of fraud or intentional misrepresentation.

Summary of Benefits for Pensioners with at least 15 but fewer than 20 years of Pension Credit

(or if you retired on a Disability Pension, with 10 years but less than 20 years of Pension Credit)

***If you have elected to participate in the MEBA Medical and Benefits Plan (by making monthly or quarterly contributions to the Plan to maintain your coverage) both you and/your dependents are eligible for the following coverage*:**

Medical Benefits	
Non-Medicare eligible coverage	***Medicare eligible coverage***
Equal to 60% of the coverage available under the Federal Medicare Program (which provides coverage at 80% of allowed charges), including the deductibles, subject to an annual deductible of $250 per individual/$500 per family.	No medical coverage.
Catastrophic Protection Rider: If a pensioner and/or dependents incur out-of-pocket expenses (Annual Deductible and co-insurance) which exceed $3,500 in a calendar year, additional covered medical expenses incurred during the remainder of the calendar year will be payable at 100% of allowed charges. Allowed charges are equal to 100% of the coverage available under the Federal Medicare Program (which normally provides coverage at 80% of covered charges). Out-of-pocket prescription drug expenses in excess of $1,500 within a calendar year, shall be payable at the rate of 100% for the remainder of the calendar year.	***Catastrophic Protection Rider:*** Not applicable.
Optical Benefit: 80% of charges incurred up to $120 in a calendar year (up to $96). If you do not use all of your annual benefit during a calendar year, the balance may be carried over for two additional calendar years, up to a maximum three-year benefit in amount equal to 80% of $360 (or $288).	***Optical Benefit:*** 80% of charges incurred up to $120 in a calendar year (up to $96). If you do not use all of your annual benefit during a calendar year, the balance may be carried over for two additional calendar years, up to a maximum three-year benefit in amount equal to 80% of $360 (or $288).

Hearing Aid Benefit: During any three consecutive calendar year period, the Plan pays: (a) 80% of charges incurred up to $3,000 for hearing aid instrument(s); (b) 80% of charges incurred up to $75 for hearing related examination(s). For dependents younger than 19, the Medical Plan will pay 80% of charges up to a maximum of $75 for a hearing related examination every calendar year.	***Hearing Aid Benefit:*** During any three consecutive calendar year period, the Plan pays: (a) 80% of charges incurred up to $3,000 for hearing aid instrument(s); (b) 80% of charges incurred up to $75 for hearing related examination(s). For dependents younger than 19, the Medical Plan will pay 80% of charges up to a maximum of $75 for a hearing related examination every calendar year.
Annual Physical: Once in a calendar year at MEBA Diagnostic Center (on or prior to June 30, 2025), Alternate Clinic, or in-network physician. Transportation benefits were payable for physicals at an MEBA Diagnostic Center for pensioners and their qualified dependents who live in excess of 75 miles from the MEBA Diagnostic Center nearest their Home of Record. Transportation allowance of up to $50 for Alternate Clinics and no transportation allowance for other physician.	***Annual Physical:*** Once in a calendar year at MEBA Diagnostic Center (on or prior to June 30, 2025), Alternate Clinic, or in-network physician. Transportation benefits were payable for physicals at an MEBA Diagnostic Center for pensioners and their qualified dependents who live in excess of 75 miles from the MEBA Diagnostic Center nearest their Home of Record. Transportation allowance of up to $50 for Alternate Clinics and no transportation allowance for other physician.
Life Benefit: $1,500 payable to a named beneficiary.	***Life Benefit:*** $1,500 payable to a named beneficiary.
Semi-Annual Reimbursement of Monthly Medicare Part "B" Premiums: Not applicable.	***Semi-Annual Reimbursement of Monthly Medicare Part "B" Premiums:*** In order to be eligible for the reimbursement, your gross monthly pension benefit, calculated as a straight life annuity, must be less than $1,000. If eligible, you must apply to the Plan to receive the reimbursement and must submit proof that you have paid the Part "B" premiums.
Outpatient Psychiatric Care: Outpatient treatment of mental and nervous disorders limited to a maximum of 100 visits per 36 months payable at 50% of allowed charges.	No coverage.

Dental Benefit: Pensioners will have one opportunity to opt in to receive retiree dental benefits. Dental benefits are provided under the Group Dental Contract, in effect with Delta Dental.	***Dental Benefit: Pensioners will have one opportunity to opt in to receive retiree dental benefits. Dental benefits are provided under the Group Dental Contract, in effect with Delta Dental.***

If you have elected to participate in the MEBA Medical and Benefits Plan (by making monthly or quarterly contributions to the Plan to maintain your coverage) and are Not Eligible for Medicare, the following coverage would apply:

Plan Feature	**Benefit**	
Calendar Year Deductible	$250 per individual/$500 per family	
Calendar Year Catastrophic Protection Out-of-Pocket Limit	$3,500 per family for Covered Medical Expenses $1,500 per family for prescription drug expenses	
Doctor's Office Services		
	PPO	**Non-PPO**
Office Visits	Plan pays 80% after you pay $20	After annual deductible, Plan pays 60% of allowable charges and you pay the rest
X-Ray and Lab Tests	Plan pays 80%	After annual deductible, Plan pays 60% of allowable charges and you pay the rest
Hospital Inpatient Services (subject to Precertification Requirements)		
	PPO	**Non-PPO**
Room and Board, (up to semi-private room rate), Inpatient Facility Charges and related lab and x-ray charges.	Plan pays 90%	After annual deductible, Plan pays 60% of allowable charges and you pay the rest
Anesthesia, Physician Consultations, Surgical Services	Plan pays 80%	After annual deductible, Plan pays 60% of allowable charges and you pay the rest

Plan Feature	Benefit	
Hospital Outpatient Services		
	PPO	**Non-PPO**
Necessary Emergency Room Treatment for Illness or Accidental Injury	Plan pays 80% after you pay $20	After annual deductible, Plan pays 60% of allowable charges and you pay the rest
Ambulatory Surgery Centers (facility fee, related lab and x-ray)	Plan pays 90%	After annual deductible, Plan pays 60% of allowable charges and you pay the rest
Anesthesia, Physician Consultations, Surgical Services	Plan pays 80%	After annual deductible, Plan pays 60% of allowable charges and you pay the rest
Inpatient Psychiatric and Alcoholism Care		
	PPO	**Non-PPO**
Inpatient Treatment of Mental and Nervous Disorders and/or Alcoholism benefits.	Plan pays 90% and you pay the rest	Plan pays 60% of allowable charges and you pay the rest
Plan Feature	**Benefit**	
Outpatient Psychiatric Care		
Office Visits for Mental and Nervous Disorders	Plan pays 80% after you pay $20	After annual deductible, Plan pays 60% of allowable charges and you pay the rest
Outpatient Care Other Than Office Visits	Plan pays 80%	After annual deductible, Plan pays 60% of allowable charges and you pay the rest
Outpatient Alcoholism and Drug-Abuse Care		
Outpatient Alcohol, Drug and other Substance Abuse	No benefits provided.	
Other		
Annual Physical: Once in a calendar year at MEBA Diagnostic Center (on or prior to June 30, 2025), Alternate Clinic, or in-network physician. Transportation benefits are also	***Annual Physical:*** Once in a calendar year at MEBA Diagnostic Center (on or prior to June 30, 2025), Alternate Clinic, or in-network physician. Transportation benefits are also payable for physicals at a MEBA Diagnostic	

Plan Feature	Benefit
payable for physicals at a MEBA Diagnostic Center for pensioners and their qualified dependents who live in excess of 75 miles from the MEBA Diagnostic Center nearest their Home of Record. Transportation allowance of up to $50 for Alternate Clinics and no transportation for other physician.	Center for pensioners and their qualified dependents who live in excess of 75 miles from the MEBA Diagnostic Center nearest their Home of Record. Transportation allowance of up to $50 for Alternate Clinics and no transportation for other physician.
Optical Care	80% of charges incurred up to $120 in a calendar year (up to $96). If you do not use all of your annual benefit during a calendar year, the balance may be carried over for two additional calendar years, up to a maximum three-year benefit in amount equal to 80% of $360 (or $288).
Hearing Aids	During any three consecutive calendar year period, the Plan pays: ▪ 80% of charges incurred up to $3,000 for hearing aid instrument(s) and you pay the rest; plus ▪ 80% of charges incurred up to $75 for hearing related examination(s) and you pay the rest. ▪ For dependents younger than 19, the Medical Plan will pay 80% of charges up to a maximum of $75 for a hearing related examination every calendar year.
Prescription Drugs	Plan pays 80% of scheduled charges and you pay the rest. Plan will pay 100% of the cost of certain over-the-counter drugs prescribed by your doctor.
Life Benefit	$1,500 payable to a named beneficiary.

Summary of Benefits for Medicare Eligible Pensioners with 20 or more years of Pension Credit.

If you have elected to participate in the MEBA Medical and Benefits Plan (by making monthly or quarterly contributions to the Plan to maintain your coverage) and are Medicare eligible, the following coverage would apply:

<table>
<tr><td colspan="2">Medical Benefits</td></tr>
<tr><td colspan="2">▪ Covered hospital, surgical and medical services are payable at 60% of usual, allowable charges, subject to annual deductible of $250 per individual/$500 per family, less reimbursement by Medicare for covered charges, whether or not enrolled in Medicare.</td></tr>
<tr><td colspan="2">Prescription Benefits – If not enrolled in Medicare Part D Plan</td></tr>
<tr><td>If OptumRx Drug Program Is Used</td><td>If OptumRx Drug Program Is Not Used</td></tr>
<tr><td>▪ 80% of the OptumRx discounted amount.
▪ Member is responsible for 20% of the OptumRx discounted amount.
▪ The 20% is paid directly to the pharmacy at the time of purchase.
▪ Pharmacy submits claim for payment.
▪ No deductible is applied.
▪ Prescriptions are limited to a 34-day supply.</td><td>▪ 80% of RETAIL cost (usual, customary and reasonable).
▪ No discount available.
▪ Full cost prescription paid to pharmacy at time of purchase.
▪ You must submit the claim for reimbursement.
▪ No deductible is applied.
▪ Prescriptions are limited to a 34-day supply.</td></tr>
<tr><td colspan="2">Catastrophic Protection Rider: If a pensioner and/or dependents incur out-of-pocket medical expenses (annual deductible, co-pays and co-insurance) which exceed $3,500 in medical expenses in a calendar year, additional covered medical expenses incurred during the remainder of the calendar year will be payable at 100%. If a pensioner and/or dependents incur out-of-pocket prescription expenses (annual deductible, co-pays and co-insurance) which exceed $1,500 in covered prescription drug expenses in a calendar year, additional covered prescription drug expenses incurred during the remainder of the calendar year will be payable at 100%.</td></tr>
<tr><td colspan="2">Optical Benefit: 80% of charges incurred up to $120 in charges in a calendar year (or $96). If you do not use all of your annual benefit during a calendar year, the balance may be carried over for two additional calendar years, up to a maximum three-year benefit in amount equal to 80% of $360 (or $288).</td></tr>
<tr><td colspan="2">Hearing Aid Benefit: During any three consecutive calendar year period, the Plan pays:
▪ 80% of charges incurred up to $3,000 for hearing aid instrument(s) and you pay the rest; plus
▪ 80% of charges incurred up to $75 for hearing related examination(s) and you pay the rest.
For dependents younger than 19, the Medical Plan will pay 80% of charges up to a maximum of $75 for a hearing related examination every calendar year.</td></tr>
</table>

Diagnostic Center Examinations: Prior to July 1, 2025, once in a calendar year. Transportation benefits are also payable for pensioners and their qualified dependents who live in excess of 75 miles from the MEBA Diagnostic Center nearest their Home of Record.
Life Benefit: $1,500 payable to a named beneficiary.
Semi-Annual Reimbursement of Monthly Medicare Part "B" Premiums: In order to be eligible for the reimbursement, your gross monthly pension benefit, calculated as a straight life annuity, must be less than $1,000. If eligible, you must apply to the Plan to receive the reimbursement and must submit proof that you have paid the Part "B" premiums.

Other Active Employees

The Plan provides benefits for non-collectively bargained employees of the Plan Office, the Union, the Calhoon MEBA Engineering School, and certain other employers that contribute to the Plan. If you are one of these employees, your coverage starts the day you complete one month of continuous employment and ends on the last day of the month during which your employment terminates. You may be eligible to continue coverage at your own cost under COBRA when your regular coverage ends.

Benefits for Non-Collectively Bargained Employees

Other Retired Employees

The Plan also provides benefits for these non-collectively bargained employees upon retirement. In general, the amount of coverage available to you and your qualified dependents is based on the number of years you worked for employers who participated in the Plan and for which those employers made contributions to the Plan on your behalf.

Please contact the Plan Office in Baltimore for more information.

Alternate Medical Plans

Depending on where you live, you and your eligible dependents may choose medical coverage under an Alternate Medical Plan instead of the MEBA Medical Plan Coverage. The Medical Plan's actuary will provide an actuarial rate that represents the maximum amount the Plan would pay to an Alternate Medical Plan. You will have to absorb any additional premium costs. If you live in an area near any of the following areas, you may be eligible to sign up for coverage by an Alternate Medical Plan:

- Hawaii
- Los Angeles, CA
- Portland, OR
- San Francisco, CA
- Seattle, WA
- Spokane, WA

Alternate Medical Plans

While you are covered by an Alternate Medical Plan, you and your qualified dependents are not eligible for any medical coverage under the MEBA Medical Plan.

Approved Alternate Medical Plans

A complete list of approved Alternate Medical Plans is available by writing to the Plan Office in Baltimore.

How Coverage Works Under the Alternate Medical Plans

If you enroll in an approved Alternate Medical Plan, your enrollment is binding for one year. Unless you notify the Plan Office in writing before the end of that period, your enrollment automatically will be renewed at the end of each year. (If you move out of a service area covered by your Alternate Medical Plan, notify the Plan Office immediately.)

When you are covered by an Alternate Medical Plan, you have no medical coverage under the MEBA Medical Plan. You also have no other type of coverage under the MEBA Medical Plan if the same type of coverage is provided by the Alternate Medical Plan.

When Coverage Terminates

If your MEBA Medical Plan eligibility terminates while you are covered by an Alternate Medical Plan, the MEBA Medical Plan will stop remitting your premiums to the elected Alternate Medical Plan. Unless you continue coverage under COBRA, you will not be entitled to coverage by an Alternate Medical Plan (or the MEBA Medical Plan) until you re-establish eligibility.

Dental Benefits

Delta Dental

Your MEBA Medical Plan Dental coverage is provided by Delta Dental as described in this Section.

Delta Dental provides an PPO network for employees and dependents to reduce the amount you pay for dental services. You are automatically covered by Delta Dental as long as you are eligible for dental coverage under the Plan. You will receive a Delta Dental identification card, which you should carry with you and present to your dentist at the time of treatment.

You will receive a Dental Program Supplement issued by Delta Dental that describes the Delta Dental coverage in detail. Your rights to dental benefits are

determined by Delta Dental under that Supplement and the Group Dental Contract between this Plan and Delta Dental. The description in this Section is a summary only and does not override the Supplement and Group Dental Contract.

You may use any dentist you like for your dental care, regardless of whether that person is a Delta Dental participating dentist.

Dentists participating in Delta Dental do not charge you for their services except for co-pays and deductibles. The co-pay is 20% of the allowable charge for the services provided. The annual deductible is $100 per calendar year per person, $300 per year per family. Participating dentists bill Delta Dental and are paid by Delta Dental directly. You pay only your co-pay and deductible.

Diagnostic and preventative services (i.e., routine exams, cleanings, x-rays and sealants) are covered at 100%, are not subject to the annual deductible, and do not count towards your annual maximum. For additional information, see the chart below.

Benefits and Covered Services	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100%	100%
Basic Services Fillings	80%	80%
Endodontics (root canals) Covered Under Basic Services	80%	80%
Periodontics (gum treatment) Covered Under Basic Services	80%	80%
Oral Surgery Covered Under Basic Services	80%	80%
Major Services Crowns, inlays, onlays and cast restorations	80%	80%

Prosthodontics Bridges, dentures and implants	80%	80%
Orthodontic Benefits Adults and dependent children	50%	50%
Orthodontic Maximums	$2,250 Lifetime	$2,250 Lifetime

If you use a dentist that is not participating in Delta Dental, you must pay your dentist for services rendered and then submit your claim to Delta Dental. As reflected in the chart above, Delta will reimburse you an amount equal to 100% of the allowable charge for the services rendered for diagnostic and preventative services, minus the deductible. You are responsible for paying your entire dental bill to the non-participating dentist, which may include charges in excess of the allowable charge.

The annual dental maximum (other than orthodontia) for Active Employees and their dependents is $2,000 per person per calendar year. The maximum benefit is based on total payments for covered services to participating and non-participating dentists.

You can determine how much of your dental treatment will be covered before treatment begins by using the Delta Dental predetermination service. Predetermination lets you know in advance what is covered and how much will be paid. Delta Dental recommends predetermination if dental treatment is expected to cost more than $300, but any claim may be predetermined if you would like an advance determination of the amount of coverage. To obtain a predetermination, have your dentist submit the proposed course of treatment to Delta Dental. Delta Dental will review the proposed course and advise both you and your dentist of the coverage that will be provided.

Pediatric Dental –
Dependent Children Under Age 19

The Plan covers dental services in accordance with the Delta Dental schedule of payments. For covered dependent children under age 19, these benefits are not subject to an annual maximum. Covered dependent

children age 19 or older are subject to the $2,000 per person annual maximum for benefits provided by Delta Dental.

Any questions about claims, eligibility and participating dentists can be directed to Delta Dental's Benefit Service Department at (800) 932-0783 between 8:00 a.m. and 8:00 p.m. (eastern time) Monday through Friday. You can also visit Delta Dental's website and access the National Dentist Directory at www.deltadental.com. You should then select the Delta Premier Plan. If your dentist does not currently participate in Delta Dental and would like to learn more about it, ask him or her to call Delta Dental toll-free, with no obligation.

All dental claims that you are required to file must be sent to Delta Dental at:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055

Of course, you can always call the Plan Office in Baltimore if you have a dental question that Delta Dental cannot answer to your satisfaction.

Claim forms for treatment by non-participating dentists are available at participating Delta Dental dentists' offices, from the Plan Office in Baltimore, or you may visit the Plan Office website at www.mebaplans.org.

Oakland MEBA Diagnostic Center's Dental Clinic

Notwithstanding anything in this Section to the contrary, prior to July 1, 2025, eligible employees and their dependents could receive basic dental services at the Oakland MEBA Diagnostic Center's Dental Clinic; provided, in no event will a duplicate treatment be provided under the Plan. Pensioners and their dependents could receive basic dental services at such clinic on a space-available basis.

Orthodontia means the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids. When provided by a licensed

Orthodontic Coverage

Orthodontic coverage is also provided by Delta Dental and is available to Active Employees and their dependents and pensioners who have opted-in to

orthodontist, such orthodontia services are covered up to a lifetime maximum of $2,250.00.

retiree dental benefits and their dependents. You should file your orthodontic claims with Delta Dental. After application of your deductible, your co-payment for orthodontia is 50%, up to a maximum lifetime orthodontia benefit of $2,250 per person.

Filing a Claim

*Claims **MUST** be filed within 12 months after the date the service or treatment was rendered. Claims filed after more than 12 months will not be paid.*

When You Need To File A Claim

You generally need to file a claim form to receive reimbursement for services by providers that do not participate in the PPO or Delta Dental.

How to File a Claim

If you need to file a claim, complete a Statement of Claim for Members and dependents (available from the Plan Office in Baltimore or you may visit the Plan Office website at www.mebaplans.org), sign it and return it to the address indicated on the form. Also, indicate on the form if you want payment to be made directly to your medical provider. All claims must be filed within one year of the date services were provided.

If your coverage is under an Alternate Medical Plan, file your claim in accordance with the Alternate Medical Plan's claims procedures.

Lost Participant or Beneficiary And Uncashed Checks

If a participant or a provider of services becomes eligible for benefits under the Plan and after making a reasonable effort to locate the person to whom the benefits are payable, the benefits otherwise payable will be forfeited as of the end of the plan year that follows the plan year in which the benefits become payable. Similarly, if a check is issued to a participant or a provider of service but remains uncashed, and after making a reasonable effort to locate the person to whom the check was issued (or if the person is located but fails to cash the check), the uncashed check will be forfeited as of the end of the plan year that includes the twelfth month after the date such check was issued. The Plan will keep a record of the undeliverable benefits or check and if the person to whom the benefits or check is payable makes proper claim for such amounts, the Plan will pay such amounts to the person, but without interest or earnings.

If A Medical Plan Claim For Benefits Or Application Is Denied

If your claim is denied, in whole or in part, you'll receive a written notice from the Plan Office, within the following time frames:

Type of Claim	Time Limit for Claim Determination	Extension Permitted
Medical, Dental, Optical		
▪ Urgent Claims (as medically determined)	72 hours	None
▪ Post-Service Claims	30 days	15 days
▪ Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
Life, Accidental Death and Dismemberment	90 days	90 days
Disability	45 days	Two 30-day extensions

If your claim lacks information required by the Plan Office to make a determination, you will be notified within a reasonable period of time. Extensions are permitted if the Plan Office determines that special circumstances beyond its control require an extension of time for processing the claim. In such case, you will be provided with written notice of the extension prior to the termination of the time for responding.

The Plan Office's notification of a claim denial will set forth the following:

- the reason(s) for the denial;
- references to the Plan provisions on which the denial is based;

- a description of any additional information that would complete or support your claim, and an explanation of why it's needed;

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination: or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;

- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- an explanation of how you can get your claim reviewed, the time limits involved, and your right to bring a civil action upon an adverse determination on appeal.

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

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

- A discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following:

    - The views you presented to the Plan of health care professionals treating you and vocational professionals who evaluated you (if any);

- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination, even if the advice was not relied upon in making the benefit determination; and

- A disability determination made by the SSA, if you provided it to the Plan;

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

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

- A statement that you are entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

- A statement regarding your right to bring a civil action under ERISA Section 502(a).

The written notice of denial will be provided in 'a culturally and linguistically appropriate manner, clearly indicating how to access the language services provided by the Plan if this applies to your claim. Additionally, a denial of your claim also includes a rescission of your disability coverage, unless it is attributable to a failure to timely pay required premiums of contributions towards the cost of coverage.

Your Right To Appeal Under The Medical Plan

If you don’t receive all of the benefits to which you feel you are entitled or if your claim is denied, in whole or in part, you or your duly authorized representative may

appeal the denial to the Board of Trustees in writing within the following timeframe:

Type of Claim	Time Limit for Appealing Denial
Medical, Dental, Optical	180 days
Accidental Death and Dismemberment, Life Insurance	60 days
Disability	180 days

You may submit written comments, documents, records, and other information relating to the claim for benefits. In addition, upon request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits and, in the case of a disability claim, a listing of medical or vocational experts whose advise was obtained on behalf of the Plan in connection with the benefit determination.

Determination on Appeal

The Trustees will make a determination of your appeal within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Appeal Determination	Extension Permitted
Medical, Dental, Optical		
▪ Urgent Claims	72 hours	None
▪ Pre-Service Claims	30 days	None
▪ Post-Service Claims	Regularly scheduled Trustees meeting (if claim received 30 days prior)	Next Trustees meeting
▪ Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
Life, Accidental Death and Dismemberment	Regularly scheduled Trustees meeting (if claim received 30 days prior)	Next Trustees meeting
Disability	Regularly scheduled Trustees meeting (if claim received 30 days prior)	Next Trustees meeting

If your claim is determined at a Trustees meeting, you will be notified in writing of the determination upon review as soon as possible but no later than five days after the determination is made.

If the denial of a claim for Medical, Dental or Optical Benefits was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual and who has appropriate training and experience in the field of medicine involved in the medical judgment. In addition, the determination on

appeal will not afford deference to the initial claim denial.

The Trustees will provide a written notification of the benefit determination on review as soon as possible but no later than five days after the determination is made. In the case of denial, the notification will set forth the following:

- the specific reason or reason(s) for the denial;
- specific reference to Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
- 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; and
- a statement of your right to sue under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Any lawsuit to recover benefits under the Plan may not be filed before exhausting all administrative remedies provided under the Plan, and must be filed within one (1) year from the date of the Trustees' written notification of the benefit determination on review,

under Section 502(a) of ERISA. The law suit must be filed in the U.S. District Court for the District of Maryland.

The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of Trustees on any claim or appeal is final and binding. The Plan's administrator's decisions should receive judicial deference to the extent that they are not arbitrary and capricious.

If Your Claim Is Denied By An Alternate Medical Plan

If your claim is denied by an Alternate Medical Plan, you must follow the Alternate Medical Plan's rules and procedures for what to do if your claim is denied.

When You Are Covered By More Than One Medical Plan – Coordination of Benefits

If you or a qualified dependent are covered under another medical plan (for example, if you are covered as a dependent under your spouse's medical plan), that plan's benefits will be coordinated with the benefits provided under the MEBA Plan.

Medical coverage under a "no fault" or medical payments provision of an automobile insurance policy is also subject to coordination with your MEBA Plan benefits. The Plan's complete coordination of benefits rules are contained in Article XVII of the Medical and Benefits Plan Rules and Regulations, and are summarized briefly below.

Under coordination of benefits, if you or any of your qualified dependents have coverage under another medical plan, the MEBA Plan and the other plan(s) will coordinate with each other to prevent duplicate benefit payments. Coordination of benefits only applies when someone has two or more medical plan coverages. If the MEBA Plan is the only plan that covers an individual

filing a claim, then coordination of benefits does not apply.

First, the “primary plan” pays all of the benefits it would normally pay without regard to any other coverage you or a dependent might have. Then, the “secondary plan” pays all of the benefits it would normally pay minus the benefits paid by the primary plan.

Primary and secondary plans are generally determined as follows:

- The plan that covers someone as an employee (rather than as a dependent) is the primary plan.
- The plan that covers someone as a dependent spouse of an employee is the secondary plan.
- The plan that covers the individual as an active employee is primary. The plan that covers the individual as a pensioner is secondary.
- For dependent children who are covered under plans of both parents, the “birthday rule” is used. Under the birthday rule, the plan of the parent whose birthday is earlier in the year is the primary plan and the plan of the parent whose birthday is later in the year is the secondary plan. (If both parents have the same birthday, then the plan that has covered the child longest is the primary plan.)

When children are covered under plans of divorced or separated parents or where the parents are not living together, or whether or not they have ever been married, the primary plan is generally determined as follows:

- If a court decree states one of the parents is responsible for the dependent child’s health care coverage, that plan is primary. If the parent with responsibility has no health care coverage, but the parent’s spouse does have health care coverage, that parent’s spouse’s plan is the primary plan.
- If a court decree states that both parents are responsible for the dependent child’s health care coverage, then refer to the “birthday rule” for determination.
- If a court decree states that both parents have joint custody but does not specify which parent is responsible for the dependent child’s health care

coverage, then refer to the “birthday rule” for determination.

- If there is no court decree which addresses responsibility for the dependent child’s health care coverage, the order of determination will be 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.

Coordination with Government and Other Programs

Medicaid*:* If an individual is covered by both this Plan and Medicaid or a State Children’s Health Insurance Program (CHIP), this Plan pays first, and Medicaid or the State Children’s Health Insurance Program (CHIP) pays second.

TRICARE*:* If a Dependent is covered by both this Plan and the TRICARE Program that provides health care services to Uniformed Service members, retirees and their families worldwide, this Plan pays first, and TRICARE pays second. For a Participant called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary, and this Plan is secondary for active Participants of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by this Plan.

Veterans Affairs/Military Medical Facility Services*:* If an individual who is covered under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical Facility on account of a military service-related illness or injury, benefits are not payable by this Plan. If an individual who is covered under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or Facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by this Plan to the

extent those services are Medically Necessary and the charges are allowed charges.

Motor Vehicle Coverage Required by Law*:* If an individual is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. This Plan's benefit coverage is excess to any vehicle insurance (including medical payments coverage/MVC, personal injury protection/PIP and/or no-fault).

Indian Health Services (IHS)*:* If an individual is covered by both this Plan and Indian Health Services, this Plan pays first, and Indian Health Services pays second.

COBRA Coverage

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

An employee may also elect COBRA continuation coverage for his or her spouse or other dependent due to the employee's termination of employment or reduction in work hours.

If you're the spouse or dependent of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse/the employee dies;
- Your spouse/the employee becomes entitled to Medicare benefits (under Part A, Part B, or both); You become divorced or legally separated from your spouse or for dependents the employee and spouse become divorced or legally separated; or
- Your dependent child loses eligibility for coverage as a dependent under the Plan

Your and your dependents' right to COBRA coverage will terminate before the end of the periods described above if:

- the required self-payment is not received on time;
- after COBRA coverage is elected, a person on COBRA coverage becomes covered by another group health plan;
- the Plan no longer provides coverage for any persons;
- after COBRA coverage is elected, a person on COBRA coverage becomes entitled to Medicare; or
- coverage was extended for up to 29 months due to disability and there has been a final determination that the person is no longer disabled.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Office.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, your spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to your spouse and any dependent children already getting COBRA continuation coverage if you die; become entitled to Medicare benefits (under Part A, Part B, or both); get divorced or legally separated; or if your dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or

- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit: https://www.medicare.gov/medicare-and-you.

Benefits While on COBRA Coverage

Active Employees

When regular employee coverage ends, you and your qualified dependents may choose between different COBRA coverage packages:

- "core plus non-core" benefits – the same medical, hearing aid, optical and dental benefits as provided to active employees;

- "core only" benefits – the same medical and hearing aid benefits as provided to active employees, but no dental or optical benefits.

In addition, use of the MEBA Diagnostic Centers (on or prior to June 30, 2025), may be elected in addition to the "core plus non-core benefits" or the "core only benefits."

Pensioners

When pensioner coverage for your qualified dependents ends, the COBRA coverage for your dependents is automatically the same medical, hearing aid, dental and optical coverage provided to pensioners. (Please note that pensioners do not have dental coverage unless they have opted-in to retiree dental benefits.)

For both active employees and pensioners, COBRA coverage does *not* include Life Insurance, Accidental Death and Dismemberment Insurance, Coast Guard Legal Aid, Disability, and Wage Insurance Benefits.

If you have questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Plan Office. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

USERRA

Uniformed Services Employment and Re-Employment Rights Act

As required under the Uniformed Services Employment and Re-Employment Rights Act ("USERRA") the Plan provides you with the right to elect continuous health coverage for you and your eligible dependent(s) for up to 24 months, beginning on the date your absence from employment begins due to military service, including Reserve and National Guard Duty, as described below. Contact the Plan Office for more information if this may apply to you.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible dependent(s)

under the provisions of USERRA. The period of coverage for you and your eligible dependent ends on the earlier of:

- the end of the 24-month period beginning on the date on which your absence begins; or
- the day after the date on which you are required but fail to apply under USERRA for or return to a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must re-apply for employment within 90 days of discharge).

After 31 days, you must pay the entire cost of coverage unless your Participating Employer elects to pay for your coverage in accordance with its military leave policy. The cost that you must pay to continue benefits will be determined in accordance with the provisions of USERRA by the same method the Plan uses to determine the cost of COBRA continuation coverage.

You must notify your participating employer or the Plan Office that you will be absent from employment due to military service unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You also must contact the Plan Office and elect continuation coverage for yourself or your eligible dependent(s) under the provisions of USERRA within 60 days from the date your military service begins. Payment of the USERRA premium, retroactive to the date on which coverage under the Plan terminated, must be made within 45 days after the date of the election of your USERRA coverage.

Questions? Contact the Plan Office

Please contact the Plan Office if:

- you have questions about COBRA;
- you have questions about USERRA;
- you have changed marital status;
- you or your spouse have changed addresses;
- you and/or any of your dependents lose eligibility for regular employee or pensioner coverage and wish to continue coverage under COBRA; or

- you will be absent from employment due to military service and wish to continue coverage under USERRA.

HIPAA

Health Insurance Portability And Accountability Act ("HIPAA")

Your health information is highly personal and the MEBA Medical and Benefits Plan is committed to safeguarding your privacy. For more information about how the Plan protects your privacy and its right to use and disclose your Protected Health Information ("PHI"), please refer to the Notice of Privacy Practices already distributed to you. If you would like another copy of that notice, please contact the Plan Office.

FMLA

Family and Medical Leave Act ("FMLA")

If you take a leave of absence from your job to care for a newborn or newly adopted child (or a child placed with you for foster care), to care for your spouse, child or parent who has a serious health condition, or because you are unable to work due to your own serious health condition, your leave may be covered by the Family and Medical Leave Act ("FMLA"). FMLA applies to covered leaves for up to 12 weeks. You may also be entitled to up to 26 weeks of leave during a 12-month period to take care of a service member who is your spouse, child, parent, or next-of-kin and is undergoing medical treatment or recuperating from serious illness or injuries as a result of their military service. While on an FMLA covered leave, your Employer may be required to make contributions to the Plan on your behalf as though you were still employed. (You may be required to repay your Employer for those contributions if you don't return to work following your FMLA leave unless you don't return because of a serious health condition or due to certain other circumstances beyond your control.)

Any days for which your Employer makes contributions while you are on FMLA leave will be considered as days worked in Covered Employment for purposes of determining your eligibility for Plan coverage.

You should contact your Employer about your rights under the FMLA.

Reimbursement and Subrogation

Reimbursement and Subrogation

Were you or your eligible dependent injured in a car accident or other accident for which someone else may be responsible? If so, that person (or his or her insurance) may be liable for paying your (or your eligible dependent's) medical expenses and these expenses would not be covered under the Plan.

If you or your dependent die before reimbursing the Plan in full, then you or your dependent's estate will be required to comply with the Plan's rules and procedures to the same extent as you or your dependent. 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.

Waiting for a third party to pay for these injuries may be difficult. Since recovery from a third party can take a long time (you may have to go to court) and your creditors will not wait patiently, as a service to you, the Plan will advance your (or your dependent's) benefits based on the requirement that you reimburse the Plan in full from any recovery you or your eligible dependent may receive, no matter how it is characterized (except an insurer on a policy of insurance issued to and in your name or your dependent's name). This means that you must reimburse the Plan if you obtain any recovery from any source, person or entity (except an insurer on a policy of insurance issued to and in your name or your dependent's name). This reimbursement and subrogation program is a service to you and your dependents. It provides for the early payment of benefits and also saves the Plan money (which saves you money too) by making sure that the responsible party pays the costs incurred as a result of your or your dependent's injuries.

You and/or your dependent are required to notify the Plan within ten days of any accident or injury for which someone else may be liable. Further, the Plan must be notified within ten 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 your name or your dependent's name).

If you or your dependent receive any benefit payments from the Plan for any illness or injury, the Plan is subrogated to all rights of recovery available to you or your dependent 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 illness or injury, to the extent of any and all related benefit payments made or to be made by the Plan on your or your dependent's behalf. This means that the Plan has an independent right to bring an action in connection with such illness or injury in your or your dependent's name and also has a right to intervene in any action brought by you or your dependent, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy (except an insurer on a policy of insurance issued to and in your name or your dependent's name).

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 you and/or your dependent actually receive 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's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your dependent in obtaining recovery. The Plan's right to full 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, “attorney’s fund” doctrine, regulatory diligence or any other defenses or doctrines. The Plan Trustees may, however, reduce the amount you or your dependent must repay in special circumstances. Whether special circumstances exist is determined by the Trustees in their sole discretion. If you or your dependent believe there are special circumstances that should reduce the amount to be repaid to the Plan, you or your dependent must make a written request to the Trustees.

The amount you or your dependent must repay (and the amount of the assignment, constructive trust, lien, and/or equitable lien by agreement) is the full amount of all benefit payments made or to be made by the Plan on your or your dependent’s behalf in connection with the illness or injury, but not more than the amount of the payment you or your dependent recover from any third party or parties in connection with the illness or injury (other than an insurer of a policy of insurance issued to and in your name or your dependent’s name). For example, if the Plan pays $1,000 in benefits for an injury and you recover $5,000, you will have to repay the Plan the full $1,000. On the other hand, if the Plan pays $5,000 in benefits for an injury and you recover only $1,000, you will only have to repay the Plan $1,000. The Plan is not required to reduce the repayment (or the constructive trust, lien and/or equitable lien by agreement) for any reason, including, but not limited to, attorney’s fees, lost wages, unpaid expenses or property damage.

The Plan has a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Plan under this Section, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the Plan until paid to the Plan. You and your dependent hereby consent and agree 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. In accordance with that constructive trust, lien, and/or equitable lien by agreement, you and

your dependent agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Consistent with the Plan's rights set forth in this Section, if you or your dependent submit claims for or receive any benefit payments from the Plan for an illness or injury that may give rise to any claim against any third party, you and/or your dependent 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 benefit payments and claims. This Subrogation Agreement also must be executed by your or your dependent's attorney, if applicable. However, even if you or your dependent or a representative of you or your dependent (including your or your dependent's attorney) do not execute the required Subrogation Agreement and the Plan nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits will constitute your or your dependent's agreement to the Plan's right to subrogation or reimbursement from any recovery by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Plan arose, and your or your dependent'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 you or your dependent recovers from a third party (excluding an insurer on a policy of insurance issued to and in your name or your dependent's name).

Any refusal by you or your dependent to allow the Plan a right to subrogation or to reimburse the Plan from any recovery your receive, no matter how characterized, up to the full amount paid by the Plan on your or your dependent's behalf relating to the applicable injury or illness, will be considered a breach of the agreement between the Plan and you that the Plan will provide the benefits available under the Plan and you will comply with the rules of the Plan. Further, by accepting benefits from the Plan, you and your dependent affirmatively waive any defenses you may have in any action by the Plan to recover amounts due under this Section or 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.

Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your dependent's claim will not be considered filed and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, 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, you or your dependent in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your dependent or your attorney may receive as a result of the accident, no matter how these amounts are characterized or who pays these amounts, as provided in this Section, are excluded under the Plan.

Under this provision, you and/or your dependent are 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 your or your dependent'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 you are asked to do so, you must contact the Plan Office immediately. You or your dependent also must do nothing to impair or prejudice the Plan's rights without the express written consent of the Plan. For example, if you or your dependent chooses not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. Where you or your eligible dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Plan authorizes the Plan to litigate or settle your claims against the third party. If the Plan takes legal action to recover what it has paid, the acceptance of benefits obligates you and your dependent (and your attorney if you have one) to cooperate with the Plan in seeking its recovery, and in

providing relevant information with respect to the accident.

You or your dependent 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 you do not, and you accept payment that is less than the full amount of the benefits that the Plan has advanced you, you will still be required to repay the Plan, in full, for any benefits it has paid. The Plan may withhold benefits if you or your dependent waives any of the Plan's rights to recovery without the express written consent of the Plan or fail to cooperate with the Plan in any respect regarding the Plan's subrogation or reimbursement rights.

If you or your dependent refuse to reimburse the Plan from any recovery or refuse 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 your and/or any of your dependents' future benefit payments 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 the Plan is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Plan, you or your dependent will pay all costs and expenses, including attorneys' 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, you or your dependent will also be required to pay interest at the rate determined by the Trustees from time to time from the date you become 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 you in

any state or federal court that has jurisdiction over the Plan's claim.

QMCSO

Qualified Medical Child Support Order

A Qualified Medical Child Support Order ("QMCSO") is a judgment, decree or court order issued by a court or state administrative agency pursuant to state domestic relations law which specifically creates or recognizes the right of a child to health benefit coverage under the Plan. The Plan will comply with a valid QMCSO to provide health coverage for any child of a participant named in a QMCSO, even if the participant does not have legal custody of the child, the child is not dependent upon the participant for support, and regardless of enrollment season restrictions which otherwise may exist for dependent coverage. If the Plan receives a QMCSO and the participant does not enroll the affected child, the Plan will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child.

A QMCSO may require that weekly disability benefits payable by the Plan be paid to satisfy child support obligations with respect to a child of a participant. If the Plan receives such an order and benefits are currently payable or become payable in the future while the order is in effect, the Plan will make payments either to the Child Support Agency or to the recipient listed in the order.

Once it is determined that a child of a participant is eligible for health benefit coverage pursuant to a QMCSO, that child must be treated as any other dependent under the Plan. In addition, the child is to be treated as a participant with respect to ERISA's reporting and disclosure requirements, so that the Plan must provide such child or the child's designated representative any information that is required to be distributed to participants, such as this Summary Plan Description. The Plan will determine who meets the requirements for this coverage, on a case by case basis. Please contact the Plan Office if you have any questions regarding QMCSOs.

Life, Accidental Death and Accidental Dismemberment Benefits

Contact the Plan Office in Baltimore in writing if you have questions about your life and accidental death benefits and accidental dismemberment benefits.

Basic Coverage

You are covered for the Basic Life, Accidental Death and Accidental Dismemberment Benefits described below when you are eligible for medical coverage under the Plan as explained earlier in this SPD. All Life, Accidental Death and Accidental Dismemberment Benefits are for employees only and do not cover dependents.

Supplemental Coverage

You are covered for the Supplemental Life, Accidental Death and Accidental Dismemberment Benefits described below if you:

- have satisfied the Basic Coverage requirements (you have medical coverage under the Plan), **and**
- have at least 400 days of covered employment within the three calendar years preceding the year of your death or accident.

How To Enroll and Name a Beneficiary

You may name anyone you wish as your beneficiary for the benefits provided by the Plan. You may name more than one person as your beneficiary. However, you must indicate what percentage of your benefit you would like each named beneficiary to receive. If you don't do this, benefits will be distributed equally among all of your named beneficiaries.

The Plan automatically enrolls you for Life, Accidental Death and Accidental Dismemberment Benefits when you become eligible for medical coverage. You don't need to complete an enrollment form, but you do need to complete a Permanent Data Form and submit it to the Plan Office in Baltimore, Maryland. You will list your beneficiary (or beneficiaries) on the Permanent Data Form. The Permanent Data Form must be completed in its entirety and must include the Social Security Numbers and addresses of all beneficiaries and state their relationship to you.

You may change your named beneficiary at any time. Changes must be made by filing a new Permanent Data Form and will become effective on the date the Plan Office receives the new Form.

Life Benefit

Your Life Benefit pays your beneficiary a benefit if you die while covered. Your beneficiary must provide satisfactory evidence of your death, such as a copy of your death certificate.

Amount of Coverage

The amount of your Life Benefit depends on whether you have Basic Coverage or Supplemental Coverage at the time of your death.

Basic Coverage

If you have Basic Coverage (you have medical coverage under the Plan), a $10,000 death benefit is payable to your designated beneficiary.

Supplemental Coverage

The total Life Benefit payable to your beneficiary if you have both Basic and Supplemental Coverage is, therefore, $40,000.

If you have Supplemental Coverage (you have Basic Coverage *and* you have 400 days of Covered Employment within the three calendar years preceding the year of your death), an additional $30,000 death benefit is payable to your designated beneficiary (in addition to the basic Life Benefit). (The 400 days of Covered Employment requirement does *not* apply and Supplemental Coverage is in effect if your death results from, and within 90 days after, an accident in the course of Covered Employment.)

When Benefits Are Not Paid

Except in certain limited circumstances set forth in the Regulations, a death benefit will not be paid to your beneficiary:

- if life insurance is payable from another policy provided for seamen by the U.S. Government; or
- when life benefits are payable under another Employer-paid policy (including self-insurance) and your death is the result of shipping operations or war.

How Benefits Are Paid

Benefits are paid in a single lump sum to your designated beneficiary after satisfactory evidence of your death is received.

If You Become Disabled

If you become totally disabled before you reach age 60 and while you're covered under the Plan, you may apply for continuation of your Life Benefit coverage. You must apply in writing within 12 months after your eligibility for medical coverage ends. Your Life Benefit coverage will continue for up to a maximum of 10 years, but will end earlier if any of the following occur:

- you stop being disabled,
- you perform any work,
- you refuse to be examined at the request of the Trustees,
- you retire under the MEBA Pension Trust (or the AMO Pension Plan), or
- your period of disability equals your total years of pension credit as of the date you become.

You must provide annual proof of your continued disability in accordance with Plan Office rules for Life Benefit coverage to remain in effect.

Accidental Death Benefit

Your Accidental Death Benefit coverage pays a benefit if you die as the direct result of an accident and within 90 days of the accident. The Accidental Death Benefit is paid in addition to the Life Benefit. Your beneficiary must provide satisfactory evidence of your death, such as a copy of your death certificate.

Amount of Coverage

The amount of your Accidental Death Benefit depends on whether you have Basic Coverage or Supplemental Coverage at the time of your death.

Basic Coverage

If you have Basic Coverage (you have medical coverage under the Plan), a $10,000 Accidental Death Benefit is payable to your designated beneficiary (in addition to the Life Benefit).

Supplemental Coverage

The total Accidental Death Benefit payable to your

If you have Supplemental Coverage (you have Basic Coverage *and* you have 400 days of Covered

*beneficiary if you have both Basic and Supplemental Coverage is, therefore, $40,000. This amount would be paid **in addition** to your Life Insurance benefit for a total death benefit of as much as $80,000.*

Employment within the three calendar years preceding the year of your death), an *additional* $30,000 Accidental Death Benefit is payable to your designated beneficiary (in addition to the Life Benefit and the Basic Accidental Death Benefit.)

How Accidental Death Benefits Are Paid

Accidental Death Benefits are paid in a single lump sum to your designated beneficiary once satisfactory evidence of your accidental death is received.

Accidental Dismemberment Benefit

Your Accidental Dismemberment coverage pays a benefit if you suffer a loss listed below as the direct result of an accident and within 90 days of the accident. You must provide satisfactory evidence that supports your claim for an Accidental Dismemberment benefit. Benefit payments are made directly to you.

Amount of Coverage

The amount of your Accidental Dismemberment Benefit depends on whether you have Basic Coverage or Supplemental Coverage

Basic Coverage

"Loss" means the following:
- *in reference to a hand or foot -- complete severance through or above the wrist or ankle joint; and,*
- *in reference to an eye -- the irrecoverable loss of the entire sight.*

If you have Basic Coverage (you have medical coverage under the Plan), the basic dismemberment benefit depends on the type of your loss, according to the following table:

Type Of Loss	Benefit Payable
Accidental loss of: ▪ one hand, or ▪ one foot	$5,000
Accidental loss of any combination of: ▪ hand(s), ▪ foot or feet, and/or ▪ sight in one or both eyes.	$10,000

The total Accidental Dismemberment benefit payable if you have covered losses and have both Basic and Supplemental Coverage could be as much as $40,000.

Supplemental Coverage

If you have Supplemental Coverage (you have Basic Coverage *and* you have 400 days of Covered Employment within the three calendar years preceding the year of your loss), supplemental dismemberment benefits are also payable, depending on the type of your loss, according to the following table:

Type Of Loss	Additional Benefit Payable
Accidental loss of: ▪ one hand, or ▪ one foot	$15,000
Accidental loss of any combination of: ▪ hand(s); ▪ foot or feet; and/or ▪ sight in one or both eyes.	$30,000

Supplemental Accidental Dismemberment benefits are in addition to the Basic Accidental Dismemberment benefits.

How Benefits Are Paid

Benefits are paid in a single lump sum to you once satisfactory evidence of your accidental dismemberment is received.

When Accidental Death and Dismemberment Benefits Are Not Paid

No Accidental Death or Accidental Dismemberment Benefits will be paid if your death or loss is the result of:

- suicide, attempted suicide or intentionally self-inflicted injury;
- disease;
- infirmity;
- ptomaine;
- bacterial infection (unless introduced through an accidental wound); or
- war.

If you have any questions about the Plan, contact the Plan Office in Baltimore.

If You Retire

If you retire and continue coverage under the MEBA Medical and Benefits Plan, your Life Benefit coverage becomes $1,500. There is no Supplemental Coverage and there are no Accidental Death or Dismemberment Benefits for retirees.

Facility of Payment

The Plan may deduct up to $1,000 from the Life Benefit or Accidental Death Benefit to reimburse any individual who has incurred burial expenses on your behalf.

Disability Benefits

If you become physically or mentally disabled so you are unable to perform your duties as a licensed officer and you require the care of a licensed physician, you are eligible for disability benefits under the Plan. You must submit to examinations required by the Trustees to determine whether you are disabled. If the Trustees determine you are disabled, the amount of the disability benefit is equal to $170 for each week you are disabled, up to a maximum benefit of $6,630 (i.e. 39 weeks). You will not receive a disability benefit until you have been disabled for seven consecutive days unless you are confined to a hospital during that time. You will not receive disability benefits or credit toward the seven day waiting period if you are on the payroll of an Employer. If you are entitled to payments for disability or worker's compensation under any state law, you will only receive the difference, if any, between the $170 and the payment under state law for each week you are disabled, up to the maximum 39 weeks.

Overpayments

If the Plan pays benefits in error, such as when the Plan pays you or your dependent more benefits than you are entitled to, or if the Plan advances benefits that you or your dependent are required to reimburse because, for example, you have received a third party recovery (see the Reimbursement and Subrogation Section of this SPD), you are required to reimburse the Plan in full and the Plan will 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 you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Plan under this Section, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the Plan until paid to the Plan. By accepting benefits from the Plan, you and your dependent consent and agree 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, you and your dependent agree 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 you or your dependent to reimburse the Plan for an overpaid amount will be considered a breach of your agreement with the Plan that the Plan will provide the benefits available under the Plan and you will comply with the rules of the Plan. Further, by accepting benefits from the Plan, you and your dependent affirmatively waive any defenses you 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 you or your dependent refuse to reimburse the Plan for any overpaid amount, the Plan has the right to recover the full amount by any and all methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your dependents' future benefit payments under the Plan. For example, if the overpayment or advancement was made to you as the Plan participant, the Plan may offset the future benefits payable by the Plan to you, or on your behalf and any of your dependents. If the overpayment or advancement was made to or on behalf of your dependent, the Plan may offset the future benefits payable by the Plan to you and any of your dependents.

The Plan also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the Plan is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Plan, you or your dependent will pay all costs and expenses, including attorneys' 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, you or your dependent will also be required to pay interest at the rate determined by the Trustees from time to time from the date you become 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 you in any state or federal court that has jurisdiction over the Plan's claim.

Notice of Non-discrimination

Notice of Nondiscrimination

The MEBA Medical and Benefits Plan ("Fund") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Human Resources Director at the Plan Office.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the Human Resources Director at the Plan Office, 1007 Eastern Avenue, Baltimore, MD 21202-4345, Phone: 410-547-9111 or 1-800-811-MEBA, Fax: 410-385-1813, email: admin@MEBAplans.org. You can file a grievance in person or by mail or email. If you need help filing a grievance, Dawn Trumps is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Taglines

ATTENTION: If you speak any of the languages below, language assistance services, free of charge, are available to you. Call 1-800-811-MEBA.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-811-6322.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-811-6322.。

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-811-6322.

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-811-6322.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-811-6322.

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-811-6322.

Korean

□ □: □ □ □ □ □ □ □ □ □ □ □, □. 1-800-811-6322.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-811-6322.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-811-6322.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-811-6322.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-811-6322.

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-811-6322.

Hindi

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Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-811-6322.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-811-6322.

Nondiscrimination Grievance Procedure

It is the policy of the MEBA Medical and Benefits Plan (“Fund”) not to discriminate on the basis of race, color, national origin, sex, age or disability. The Fund has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the Plan Office, 1007 Eastern Avenue, Baltimore, MD 21202-4345. You can contact the Plan’s Section 1557 Coordinator, Phone: 410-547-9111 or 1-800-811-MEBA, Fax: 410-385-1813, email:

admin@MEBAplans.org, who has been designated to coordinate the efforts of the Fund to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for the Fund to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.

- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

- The Section 1557 Coordinator (or his designee) will conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of the Fund relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing

to the Fund’s Board of Trustees within 15 days of receiving the Section 1557 Coordinator's decision. The Fund’s Board of Trustees will issue a written decision in response to the appeal no later than 30 days after its filing.

- The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

- Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

- The Fund will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Other Plan Information

PLAN SPONSOR

The Plan Sponsor is the Board of Trustees of the MEBA Medical and Benefits Plan. Members of the Plan's Board of Trustees as of December 1, 2025 are:

UNION TRUSTEES	EMPLOYER TRUSTEES
Adam Vokac President District No. 1-PCD, MEBA 444 North Capitol Street, NW Suite 800 Washington, DC 20001-1570	Edward Hanley Vice President, Labor Relations MAERSK Lines, Limited One Commercial Place, 20th Floor Norfolk, VA 23510-2103
Roland Rexha Secretary Treasurer District No.1-PCD, MEBA 444 North Capitol Street, NW Suite 800 Washington, DC 20001-1570	Kerri Bancroft Manager for Marine Labor Relations and Manning OSG Ship Management, Inc. 302 Knights Run Avenue Suite 1200 Tampa, FL 33602
Jason Callahan Vice President, Atlantic Coast District No. 1-PCD, MEBA 37 Edward Hart Drive Jersey City, NJ 07305	Boriana Farrar Vice President – Chief Legal Officer Patriot Contract Services 1320 Willow Pass Road Suite 485 Concord, CA 94520
Adam Smith Vice President, Gulf Coast District No. 1-PCD, MEBA 811 Carondelet Street New Orleans, LA 70130	Cam Rathborne Executive Vice President Keystone Shipping Co. 1 Bala Plaza #E600 Bala Cynwyd, PA 19004
Maxim Alper Executive Vice President District No. 1-PCD, MEBA 548 Thomas L. Berkley Way Oakland, CA 94612	Captain John W. Sullivan Vice President-Vessel Operations Matson Navigation Company, Inc. 555 12th Street Suite 800 Oakland, CA 94607

Nicole Greenway Branch Agent, Tampa District No. 1-PCD 2018 E. 7th Ave., Tampa, FL 33605	William Thornton Vice President, CFO, and Treasurer Interlake Steamship Company 7300 Engle Road Middleburg Heights, OH 44130-3429

The Board of Trustees can be contacted at the following address and phone number:

1007 Eastern Avenue
Baltimore, MD 21202-9111
410-547-9111
(800) 811-6322 (MEBA)

EMPLOYER IDENTIFICATION NUMBER

The Plan's employer identification number is 13-5590515. The plan number is 501.

PLAN YEAR

The Plan Year for the Medical Plan is January 1 through December 31.

PLAN ADMINISTRATOR

The Plan Administrator for the Medical Plan is the Board of Trustees listed above; you can contact the Plan Administrator at the following address:

1007 Eastern Avenue
Baltimore, MD 21202-9111
410-547-9111
(800) 811-6322 (MEBA)

If you have any questions about any of the information in this SPD or would like to request a Plan Document, you should write to or call the Plan Office.

AGENT FOR SERVICE OF LEGAL PROCESS

Legal process can be served on any Trustee or the Plan Administrator at this address:

1007 Eastern Avenue
Baltimore, MD 21202-9111

410-547-9111
(800) 811-6322 (MEBA)

MEBA MEDICAL AND BENEFITS PLAN COSTS AND ADMINISTRATION, TYPE OF WELFARE PLAN

Insured Active Life and Accidental Death and Dismemberment Benefits are underwritten by UNUM Life Insurance Company of America, 15 Corporate Place South, PO Box 1387, Piscataway, NJ 08855-1387. All other benefits are provided on a self-funded basis.

The Plan is intended to be a welfare plan providing self-funded medical and prescription drug benefits and fully-insured disability and life insurance benefits.

SOURCES OF CONTRIBUTIONS TO THE PLAN

Sources of contributions to the Plan are Participating Employers pursuant to the terms of their collective bargaining agreements or participation agreements and self-payments made by participants and/or dependents. Retired participants are also required to contribute to the Plan to obtain coverage under the Plan.

IDENTITY OF FUNDING MEDIUM

Fund assets are held in trust for the exclusive benefit of participants and beneficiaries and to defray reasonable administrative expenses.

COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained in accordance with collective bargaining agreements. You may obtain a copy of the agreement applicable to you upon written request to the Plan Office and are available for examination by you and your beneficiaries at the Plan Office.

PARTICIPATING EMPLOYERS

You may receive from the Plan Office, upon written request, information as to whether a particular employer participates in the sponsorship of the Medical Plan. You may also receive the employer’s address if the employer is a Participating Employer.

ANTI-ASSIGNMENT OF BENEFITS

Plan participants and dependents may not assign, transfer, or convey any of the benefits provided by the Medical Plan, except pursuant to a Qualified Medical Child Support Order ("QMCSO"). Benefits are also not subject to any creditor's claim or to legal process by any creditor of any covered individual, except pursuant to a QMCSO. Similarly, a participant or dependent cannot assign, transfer, or convey any rights that he or she has or may have under the Medical Plan or ERISA. This prohibition on assignments of rights specifically includes, but is not limited to, any legal right to bring claims for benefits or to appeal claims determinations, breaches of fiduciary duty, prohibited transactions, statutory violations and statutory penalties. Any attempt to assign any Medical Plan benefits or legal rights to any third party, including, but not limited to, a healthcare provider, will be immediately invalid, void, and unenforceable. The purported assignments you may be asked to sign by a healthcare provider, at or around the time of service, do not invalidate, alter or supersede these prohibitions.

The Plan Administrator, in its sole and absolute discretion, may decide to pay benefits due to you or a dependent under the terms of the Medical Plan directly to your healthcare provider. When this happens, it is done solely for your convenience. Nothing in this document or the Medical Plan obligates the Medical Plan to pay any benefits directly to any healthcare provider or alters the Medical Plan's prohibition on assigning rights and benefits under the Medical Plan. Nor does the payment of benefits directly to a healthcare provider constitute an acceptance of any assignment.

Although, as described above, you may not assign to a healthcare provider your right to file an appeal under the Plan's appeals procedures or to file a suit for benefits, you may allow a healthcare provider to act as your authorized representative in an appeal under the Plan's appeals procedures.

RIGHT TO AMEND OR TERMINATE PLANS

The Trustees reserve the right to amend or terminate any of the Plans at any time pursuant to the respective Declarations of Trust. Such amendments or modifications may be retroactive, if necessary, as determined by the Trustees in their discretion, to meet statutory requirements or for any other reason.

YOUR BENEFITS AND ERISA

Participants in the Medical Plan described in this SPD are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended, which is also known as ERISA.

ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

Obtain, upon written request to the Plan Administrator, copies of all documents governing the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Office may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your

dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the rights described above. For example, if you request a copy of the Plan documents or the latest annual report from the Plan and don’t receive them within 30 days, you may file suit in a state or Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If your claim for benefits is denied or ignored, in whole or in part, you also may file suit in Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay

court costs and legal fees. If you are successful, the court may order the persons you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for instance, if it finds your claim frivolous. As stated above, all suits must be filed in the U.S. District Court for the District of Maryland and within the time limits noted above.

Assistance With Your Questions

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

Finally, please don't hesitate to contact the Plan Office in Baltimore if you have questions or problems with the Medical Plan.

* * *

As noted above, while the Board of Trustees expects to continue these Plans, the Board of Trustees may act at any time to amend or terminate any Plan described in this Handbook.

This Summary Plan Description is a Summary of the Plan as in effect on January 1, 2025 (or as specified herein). Terms and phrases used in this SPD are intended to have the meanings given them in the Plan Rules and Regulations. If there's any difference between the information contained in this SPD and the Plan Rules and Regulations, the Plan Rules and Regulations, as interpreted by the Board of Trustees, will always govern. If there are legal rules that require changes not yet written into the Plan Rules and

Regulations, the Plan Rules and Regulations will be interpreted by the Board of Trustees as including those legal rules.

APPENDIX A

Travel Policy

Travel Agency

- The Medical Plan has arranged to have an in-house Travel Coordinator who works directly with the Medical Plan's contracted travel organization (the "Travel Agency") to provide travel services to active and retired participants ("Participants") and their eligible dependents ("Dependents") attending the MEBA Diagnostic Centers.
- Use of the Travel Agency is mandatory to receive reimbursement of all air travel expenses.
- Participants must make the initial payment for travel expenses and will be reimbursed by the Medical Plan subject to the limits of this Policy.

Home of Record

- All travel reimbursement will be made based on the Participant's 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 included on a list designated by the Trustees of major Continental United States airports that is closest to the Participant's home of record.

Frequency of Reimbursement

- Reimbursement of round-trip transportation will be afforded to a Participant and/or Dependent to travel to the MEBA Diagnostic Center nearest the Home of Record.
- 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 MEBA School immediately before or after a MEBA Diagnostic Center exam will not be reimbursed under this policy.
- Round-trip reimbursement will be paid by the Plan Office in Baltimore, upon receipt of a completed claim. If reimbursement is made to a Participant or Dependent and it is later discovered that the ticket was not used, the Participant and his Dependents will not be allowed to be seen at a MEBA Diagnostic Center until such time as the reimbursement is repaid to the Medical Plan.

Maximum Reimbursement

- Reimbursement for travel by airplane will be based upon coach air fare actually paid subject to the maximum reimbursement herein. Airfare will not be reimbursed if the Participant's Home of Record is 75 miles or less from the nearest MEBA Diagnostic Center.

- For the purpose of all transportation reimbursement, the maximum reimbursement will be the fares available through the Travel Agency calculated from the minimum cost of round-trip, non-refundable, seven-day, advance purchase coach air fare as determined by the Travel Agency.
- In order to maximize fare reductions and thereby reduce travel expense for the Medical Plan, Participants and Dependents are encouraged to make and confirm travel arrangements with the Travel Agency 21 days or more in advance.
- Reimbursement for travel by train or bus will be based upon actual transportation fare incurred; however reimbursement will not exceed the maximum amount payable had the Participant or Dependent traveled by air and used the Travel Agency. Travel by train or bus will not be reimbursed if the Participant's Home of Record is 75 miles or less from the nearest MEBA Diagnostic Center.
- Reimbursement for travel by automobile will be based upon mileage, payable at the IRS mileage allowance then in effect, and will not exceed the maximum amount payable had the Participant or Dependent traveled by air and used the Travel Agency. The maximum reimbursable mileage will be computed on the basis of the publicly available internet map used by the Travel Agency (such as Google Maps). For automobile travel in excess of 400 miles one way, gasoline and/or hotel receipts must be presented to establish travel but reimbursement will be at the IRS mileage rate and gasoline, tolls, and hotel will not be reimbursed. Mileage will not be reimbursed if the Participant's Home of Record is 75 miles or less from the nearest MEBA Diagnostic Center.
- Travel from a location other than a Participant's Home of Record will be reimbursed but will not exceed the maximum amount payable had the Participant or Dependent traveled by air from his Home of Record and used the Travel Agency.
- 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 provided the Travel Agency is used to arrange air travel.
- With proper documentation, travel arranged less than seven days in advance will be reimbursed at the round-trip, non-refundable coach fare only for Participants discharged from a vessel within the seven-day window preceding their visit to the MEBA Diagnostic Center.
- Participants and Dependents will be reimbursed for original booking fees charged during normal operating hours of the Travel Agency.
- Other than original booking fees assessed during normal operating hours, fees for after-hours bookings or changes will not be reimbursed.
- Change or cancellation fees will not be reimbursed; however, if a MEBA Diagnostic Center exam is cancelled by the Diagnostic Center and a ticket has already been purchased, normal airline cancellation fees or change fees for another appointment will be reimbursed.

Miscellaneous Allowance

- A miscellaneous travel expense allowance of $20 per family per calendar year will be paid in addition to the travel reimbursement.

- The allowance will 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.
- The miscellaneous allowance will be paid by the Plan Office when the travel reimbursement is paid.

Travel Arrangements

- For travel by airplane, non-stop or one-stop direct flights are preferable; however, one-stop connecting flights are acceptable so long as the travel time is not extended by more than 120 minutes over non-stop flights.
- Should such flights be unavailable, multiple-stop direct or connecting flights may be arranged.
- 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 to be eligible for reimbursement.

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 reports issued by the Travel Coordinator or Travel Agency may be accepted for reimbursement in lieu of actual tickets, boarding passes and receipts.

Notwithstanding anything in this Policy to the contrary, in certain limited circumstances the Administrator may approve reimbursement of travel expenses that a Participant incurs but for which the Travel Agency is not used if 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 Medical Plan.

APPENDIX B

No Surprises Act Services

The Plan has been amended to conform with the requirements of the No Surprises Act. These changes are described in this Appendix and are effective January 1, 2022.

Throughout this Appendix, there are capitalized terms that have special meanings. These special meanings are defined below in the section entitled "Definitions."

No Surprises Act Services

1. General. As described in this Appendix, "No Surprises Act Services" are made up of the following:

    a. non-PPO Emergency Services (as defined below);

    b. non-PPO air ambulance services that are medically necessary;

    c. non-emergency Ancillary Services (as defined below) for anesthesiology, pathology, radiology, neonatology and diagnostics, when performed by a non-PPO provider at a participating Health Care Facility (as defined below); and

    d. 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 (as defined below) requirements.

    No Surprises Act Services described in this Appendix are subject to applicable Cost Sharing (as defined below). In addition, if a Covered Individual (as defined below in the definition "Cost Sharing") receives No Surprises Act 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 Surprises Act Services provided by that non-PPO provider will be covered as if the provider was a PPO provider.

2. Emergency Services. Emergency Services (as defined below) are covered without the need for prior authorization.

3. Continuity of Coverage for Eligible Employees, their Dependents and Pensioners. If a Covered Individual is a Continuing Care Patient (as defined below) and the PPO terminates its contract with a PPO provider or facility that is treating that Covered Individual, the Plan will do the following:

    a. 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 his or her right to elect continued transitional care from that provider or facility; and

b. 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 facility, to allow for a transition of care to a PPO provider.

4. No Surprises Act Services Received by an Eligible Employee, Pensioner or their Dependents.

   a. *Eligible Employees*. Regardless of anything in this SPD to the contrary, No Surprises Act Services received by an eligible employee will be covered subject to the Plan's applicable Cost Sharing.

   b. *Pensioners*. Regardless of anything in this SPD to the contrary, No Surprises Act 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.

5. Adverse Benefit Determination Related to No Surprises Act Services. If you receive an adverse benefit determination that relates to a No Surprises Service, you 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 will, within five business days following the receipt of the external review request, receive a preliminary review to determine whether:

   - you are or were 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 Act Services;
   - you exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeal process; and
   - you have provided all the information and forms required to process an external review.

   Within one business day after completion of the preliminary review, the Plan Office will issue a written notification of its determination to you, 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, you will 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 will refer the matter to an IRO. The determination of the IRO will 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 will immediately provide payment for the No Surprises Service claim.

6. Definitions. The capitalized terms in this Appendix have the meanings as described below:

    a. "*Ancillary Services*" means, with respect to a participating Health Care Facility:

        i. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
        ii. Items and services provided by assistant surgeons, hospitalists, and intensivists;
        iii. Diagnostic services, including radiology and laboratory services and subject to exceptions specified by federal regulation; and
        iv. 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.

    b. "*Continuing Care Patient*" means a Covered Individual who is:

        i. undergoing a course of treatment for a Serious and Complex Condition (as defined below);
        ii. scheduled to undergo non-elective surgery (including any post-operative care);
        iii. pregnant and undergoing a course of treatment for the pregnancy;
        iv. determined to be terminally ill and receiving treatment for the illness; or
        v. undergoing a course of institutional or inpatient care from the provider or facility.

    c. "*Cost Sharing*" or "*Cost Share*" means the amount a Covered Individual (as defined below) 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. A Covered Individual's Cost Share applicable to No Surprises Act Services is based on the lesser of the Qualifying Payment Amount (as defined below) payable for such services or the amount billed by the non-PPO provider. Coinsurance amounts paid for No Surprises Act Services will count towards a Covered Individual's PPO annual deductible, as described in the Plan and this SPD, and any applicable PPO out-of-pocket maximums, as may apply under the

Plan and this SPD, but not non-PPO annual deductibles or non-PPO out-of-pocket maximums.

d. "*Covered Individual*" means each of an eligible employee, pensioner, or their dependent(s).

e. "*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.

f. "*Emergency Services*" means, with respect to an Emergency Medical Condition (as defined above):

    i. 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 defined below), as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
    ii. 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).
    iii. 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:

        1. The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;
        2. 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
        3. The Covered Individual gives informed Consent (as defined below) 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.

g. "*Health Care Facility*" (for non-Emergency Services) means each of the following:

   i. A hospital (as defined in section 1861(e) of the Social Security Act);
   ii. A hospital outpatient department;
   iii. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
   iv. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

h. "*Independent Freestanding Emergency Department*" means 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.

i. "*Notice and Consent*" or "*Consent*" with respect to services provided at a participating Health Care Facility by a non-PPO provider, means:

   i. 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
   ii. 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.

j. "*Qualifying Payment Amount*" means 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.

k. "*Serious and Complex Condition*" means one of the following:

i. 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
ii. In the case of a chronic illness or condition, a condition that is the following:

    1. Life-threatening, degenerative, potentially disabling, or congenital; and
    2. Requires specialized medical care over a prolonged period of time.

APPENDIX C

Department of Labor Online Security Tips

You can reduce the risk of fraud and loss to your data and health information by following these basic rules:

- **Set up and routinely monitor your online account**
    - Regularly check your claims online to reduce the risk of fraudulent account access.
    - Failing to register for an online account may enable cybercriminals to assume your online identity.
- **Use strong and unique passwords**
    - Do not use dictionary words.
    - Use letters (both upper and lower case), numbers, and special characters.
    - Do not use letters and numbers in sequence (no “abc,” “567,” etc.).
    - Use 14 or more characters.
    - Do not write passwords down.
    - Consider using a secure password manager to help create and track passwords.
    - Change passwords every 120 days, of it there’s a security breach.
    - Do not share, reuse, or repeat passwords.
- **Use multi-factor authentication**

- Multi-factor authentication (also called two-factor authentication) requires a second credential to verify your identity (for example, entering a code sent in real-time by text message or emails).

- **Keep personal contact information current**
  - Update your contact information when it changes, so you can be reached if there is a problem.
  - Select multiple communication options.
- **Close or delete unused accounts**
  - The smaller your on-line presence, the more secure your information. Close unused accounts to minimize your vulnerability.
  - Sign up for account activity notifications.
- **Be wary of free Wi-Fi**
  - Free Wi-Fi networks, such as the public Wi-Fi available at airports, hotels, or coffee shops pose security risks that may give criminals access to your personal information.
  - A better option is to use your cellphone or your home network.
- **Be aware of phishing attacks**
  - Phishing attacks aim to trick you into sharing your passwords, account numbers, and sensitive information, and gain access to your accounts. A phishing message may look like it comes from a trusted organization, to lure you to click on a dangerous link or pass along confidential information.
  - Common warning signs of phishing attacks include:
    - A text message or email that you did not expect or that comes from a person or service you do not know or use.
    - Spelling errors or poor grammar.
    - Mismatched links (a seemingly legitimate link sends you to an unexpected address). Often, but not always, you can spot this by hovering your mouse over the link without clicking on it, so that your browser displays the actual destination.
    - Shortened or odd links or addresses.

        - An email request for your account number or personal information (legitimate providers should never send you emails or texts asking for your password, account number, personal information, or answers to security questions).
        - Offers or messages that seem too good to be true, express great urgency, or are aggressive and scary.
        - Strange or mismatched sender addresses.
        - Anything else that makes you feel uneasy.

- **Use antivirus software and keep apps and software current.**
    - Make sure that you have trustworthy antivirus software installed and updated to protect your computers and mobile devices from viruses and malware. Keep all your software up to date with the latest patches and upgrades. Many vendors offer automatic updates.

- **Know how to report identity theft and cybersecurity incidents.**
    - The FBI and the Department of Homeland Security have set up valuable sites for reporting cybersecurity incidents:
        - **https://www.fbi.gov/file-repository/cyber-incident-reporting-united-message-final.pdf/view**
        - **https://www.cisa.gov/reporting-cyber-incidents**