MEBA Benefit Plans
Safeguarding MEBA Members and Families

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MEBA MEDICAL AND BENEFITS PLAN
SUMMARY OF MATERIAL MODIFICATIONS

This Summary of Material Modifications advises you of changes in the information contained in the MEBA Medical and Benefits Plan Summary Plan Description ("SPD"), as required by the Employee Retirement Income Security Act of 1974. The Trustees of the MEBA Medical and Benefits Plan (the "Plan") have amended the Plan to (1) provide additional coverage for colorectal cancer screenings; (2) provide additional hearing aid benefits; (3) provide additional coverage for outpatient treatment of mental and nervous disorders for Pensioners; (4) provide that with respect to alcohol, drug, and other substance abuse benefits, a "Legally Qualified Physician" includes a substance abuse professional; and (5) provide additional coverage for Eligible Employees for inpatient substance abuse disorder benefits provided at PPO residential treatment centers. These changes are described below:

1. The Trustees have amended the Plan with respect to the definition of "Legally Qualified Physician." Accordingly, effective September 1, 2019, the Section "Legally Qualified Physician" on page 12 of the SPD is modified to read as follows:

   Licensed Qualified Provider

   Except as specifically stated otherwise in this SPD or the Rules and Regulations, the Medical Plan only covers services provided by a Licensed Qualified Provider. A Licensed Qualified Provider is a person who is duly licensed to (1) prescribe and administer any drugs, (2) perform surgical procedures, (3) perform chiropractic manipulations, or (4) who is a certified nurse midwife or certified registered nurse anesthetist, or (5) with respect to the coverage of nervous and mental disorders, any mental health practitioner who is either licensed or certified by the State in which he/she practices or (6) 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 license. Also, physiotherapy performed under the supervision of a Licensed Qualified Provider is covered (but subject to maximum visit limits).

2. The Trustees have amended the Plan to add coverage for active employees only (not dependents) for inpatient stays at residential treatment centers when seeking treatment for substance abuse disorders, provided the residential treatment center

is a PPO preferred provider. Accordingly, effective January 1, 2020, the Section "Alcohol, Drug and Other Substance Abuse" on page 14 is modified to read as follows:

Alcohol, Drug and Other Substance Abuse

The Medical Plan covers 100% of the reasonable and customary charges for the care and treatment of alcoholism and drug and other substance abuse. For active employees only, this includes inpatient stays at residential treatment centers that are part of the Medical Plan's PPO network.

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.

3. The Trustees have amended the Plan with respect to coverage for hearing aids. Accordingly, effective January 1, 2020, the Section "Hearing Aid Benefit" on page 15 of the SPD is modified to read as follows:

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) 80% of charges incurred up to a maximum of $75 for hearing related examination(s) and you pay the rest. (When filing a claim, you must include a recommendation for a hearing aid from a Legally Qualified Physician.) For dependents younger than 19, the Medical Plan shall pay 80% of charges up to a maximum of $75 for a hearing related examination every calendar year.

4. The Trustees have amended the Plan to add coverage for colorectal cancer screenings, in addition to the routine colonoscopies the Plan already covers. Accordingly, effective January 1, 2020, the Section "Colonoscopies Covered 100%" on page 20 is modified to read as follows:

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 five years as follows:

- At age 50 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.

5. The Trustees have amended the Plan with respect to coverage of outpatient treatment of mental and nervous disorders for Pensioners. Accordingly, effective January 1, 2020, the Section "Summary of Benefits for Pensioners with at least 15 but fewer than 20 years of Pension Credit" on page 51 of the SPD is modified to add the following:

Non-Medicare eligible coverage	***Medicare eligible coverage***
***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.

6. As noted above, the Trustees have amended the Plan with respect to coverage of outpatient treatment of mental and nervous disorders for Pensioners. Accordingly, effective January 1, 2020, the Section "Summary of Benefits for Non-Medicare Eligible Pensioners with 20 or more years of Pension Credit" on page 54 of the SPD is modified to read as follows:

Plan Feature	**Benefit**
Outpatient Psychiatric Care	
Outpatient Treatment of Mental and Nervous Disorders (benefits limited to a maximum of 100 visits per 36 months)	Plan pays 50% of reasonable and customary charges and you pay the rest

7. The Trustees have modified the Plans' General COBRA Notice. Accordingly, the Section "COBRA Coverage" on page 68 of the SPD is modified to read as follows:

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.

If you're the spouse 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 dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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[1] 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.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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.

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.

8. The Trustees have clarified the Plan's subrogation and reimbursement rights. Accordingly, the Section "Reimbursement and Subrogation" on page 76 of the SPD is modified to add the following at the end:

   If you or your dependent die before reimbursing the Plan in full, then you or your dependent's estate is 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.

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

Ann S. Gilchrist, Administrator