MAINE EDUCATION ASSOCIATION
BENEFITS TRUST
HEALTH PLAN
July 1, 2022

SUMMARY PLAN DESCRIPTION

The benefits under the health plan are provided through a Voluntary Employees' Beneficiary Association (VEBA) which is exempt from Federal and State taxation as provided in Internal Revenue Code Section 501(c)(9). The operation and administration of the plan and the VEBA are also subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA) which protects the rights of participants in the plan. (See "ERISA Rights" in this Summary Plan Description.)

Your benefits and other rights are described in the Certificate of Coverage specific to your health plan options, and the Certificate of Coverage is incorporated by reference into this Summary Plan Description. If there is a question concerning a claim for benefits or denial of a claim for benefits, the employer, the MEA Benefits Trust, and such other individuals as may be party to or associated with the plan, shall be guided solely by the Certificate of Coverage and this Summary Plan Description.

For the protection of the interests of the plan participants and their dependents, benefits under the plan cannot be assigned and, to the extent permitted by law, are not subject to garnishment or attachment. However, the benefits may be the subject of a domestic relations order.

The MEA Benefits Trust fully intends to continue the plan indefinitely. However, in order to protect against unforeseen situations, the Trust reserves the right to change the terms of the plan or to terminate the plan, if necessary.

GENERAL INFORMATION

Name of Plan and Type of Administration and Funding Medium:
The Maine Education Association Benefits Trust provides health care coverage through its insured contracts with Anthem Blue Cross and Blue Shield. The Trust is managed by a Board of Trustees whose members are named below.

Plan Sponsor:
Maine Education Association
35 Community Drive
Augusta, ME 04330-9487
Telephone No. 1-800-452-8709

Employer Identification Number (EIN):
01-0479776

Plan Number: 501

Type of Benefits Provided:
Health and Vision Benefits

Plan Administrator:
Maine Education Association
Attn. MEABT Administrator
35 Community Drive
Augusta, ME 04330-9487
Telephone No. 1-800-452-8709

Trustees of the Plan: (and their successors Trustee as appointed from time to time)
A current list of Trustees is located at www.meabt.org

Robin Colby Chair Waterville	Sonya Verney Vice Chair Newcastle
Jill Plourd Secretary Gardiner	Lindsey Dos Santos Trustee Augusta
Donna Longley Trustee Saco	Patty Scully Trustee Waterville
Jesse Hargrove Trustee Thorndike	Faith Campbell Trustee Sandy Point
Hal Perry Trustee Rockland	

Address for Trustees:
[Name of Trustee]
c/o MEA Benefits Trust
35 Community Drive
Augusta, ME 04330-9487
1-866-622-4418

Agent for Service of Legal Process.
While the Trustees believe that any disagreement over claims can be resolved equitably and fairly, if litigation becomes necessary, the Agent for Service of Legal Process is:

Executive Director
MEA Benefits Trust
35 Community Drive
Augusta, ME 04330-9487

In addition, service of legal process may be made upon any Plan Trustee or the Plan Administrator.

Plan Year: July 1 – June 30

Applicable Collective Bargaining Agreement.
Refer to your own collective bargaining agreement.

Source of Financing of the Plan and Provider of Benefits.
Contributions are paid by the employer and employees, and the contributions are paid to Anthem Blue Cross and Blue Shield on a monthly basis. All contributions must be received by the beginning of each month for which they are due. Benefits are provided directly through Anthem Blue Cross and Blue Shield.

ELIGIBILITY

Subscriber eligibility is dependent upon the educational units' membership in the MEA Benefits Trust health plan. The eligibility for active employees and retirees is determined by the administrative guidelines of the MEA Benefits Trust, which can be found on the MEA Benefits Trust website at:
http://meabt.org/documents
under the "Member" heading or by requesting a copy from the Plan Administrator. An active employee must be employed at least 15 hours per week to be eligible to participate in the MEA Benefits Trust health plan.

Professional and support educators, and their eligible dependents, who are employed in education may also be eligible to participate in the MEA Benefits Trust health plan, subject to the administrative guidelines of the Trust.

COVERAGE EFFECTIVE DATES

As long as paperwork is submitted within 60 days of the date of hire or qualifying event, coverage will begin on the first day of the month following the date the signed application is received by Anthem.

OPEN ENROLLMENTS

For employees actively employed by an MEA Benefits Trust participating school, selection periods shall be held each year from May 1st through May 31st of the year of the contract during which all eligible employees currently enrolled in the health insurance program shall be given the option to:

a. remain with, or change to the MEABT Standard plan at his/her current level of coverage;

b. remain with, or change to, the MEABT Choice Plus plan at his /her current level of coverage;

c. remain with, or change to the MEABT Standard 500 plan at his/her current level of coverage;

d. remain with, or change to, the MEABT Standard 1000 plan at his/her current level of coverage.

The effective date of changes made during the selection period shall coincide with the bargaining units' contract effective date.

CONTINUATION OF COVERAGE

Basic rules: A participant is eligible to continue coverage under the MEA Benefits Trust health plan after terminating employment if the participant has (a) 10 years of continuous active service and health plan coverage, and active service and health plan coverage for the 12 months prior to termination (no age limit), or (b) 5 years of continuous active service and health plan coverage, and active service and health plan coverage for 12 months prior to termination (minimum age 50). Please contact the Trust with questions or concerns about eligibility.

The participant's employer must be in the MEA Benefits Trust health plan on the participant's date of termination of employment, and such employer must continue to participate in the health plan thereafter (as retirees are required by Maine law to be covered under the plan or policy covering active employees from the same school unit).

If a participant is eligible to continue coverage, he or she shall be entitled to one break in coverage which may last no longer than 5 years. During the break, the participant must be covered by comprehensive health insurance similar to the MEA Benefits Trust health plan. The break must cease within the 5 year period or when the participant attains age 62, whichever comes first. The break cannot commence after an employer decides to leave the MEA Benefits Trust health plan. The participant is not considered to be on a break if he or she is covered as a dependent of another participant in the health plan.

DEPENDENT SURVIVOR

If an active or retired member dies while insured under the contract, the insured surviving spouse

and dependent children may continue group health coverage if they are eligible for benefits or if they are eligible for the survivor benefit allowance from the Maine State Retirement System. Please contact the MEA Benefits Trust for information.

RETIREMENT INFORMATION

When you retire, please contact your superintendent's office and follow the necessary steps to transfer your coverage. THIS IS NOT DONE AUTOMATICALLY. Should you remarry after retiring, a new spouse and dependent children are eligible for coverage, but only if enrolled within 60 days of the marriage. Coverage will begin the first of the month following receipt of the application.

If you retire at age 65 and are enrolled in Medicare Parts A and B, your coverage will be converted to the MEA Medicare Advantage Plan (Anthem Medicare Preferred (PPO) with Senior Rx Plus). Check with your local Social Security office three months before you turn 65 to determine if you are eligible for Medicare Part A. It is your responsibility to purchase Medicare Part B (if you apply for Part B, it will automatically be deducted from your Social Security check).

Those who retire and are not eligible for Part A of Medicare may continue with the MEA Benefits Trust health plan.

Once you are participating in the retiree group health plan and have attained age 62 or older, if you leave the plan, you cannot return to our retiree group health plan.

Qualified Medical Child Support Order.
Participants and beneficiaries can obtain, without charge, a copy of the procedures governing qualified medical child support order ("QMCSO") determinations from the Plan Administrator.

Special Enrollment.
Your Certificate of Coverage describes rules relating to special enrollment rights to which you may be entitled. For a discussion of these topics, you should consult your Certificate of Coverage, which is incorporated by reference herein.

Health Care Rights of Mothers and Newborns.
Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a 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 provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtains authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Claims Procedures.
Your Certificate of Coverage describes procedures surrounding the benefit claims process. For issues relating to the claims procedures, you should consult your Certificate of Coverage, which is incorporated by reference herein.

Request for Assistance.
As stated above, your Certificate of Coverage explains the claims review process, including your right to appeal an adverse decision. Following the appeal process described in the Certificate of Coverage, participants shall have the right to request an external review, file a complaint with the Bureau of Insurance and / or bring a legal action against Anthem Blue Cross and Blue Shield.

In addition to the foregoing, a participant may also request assistance from the Board of Trustees of the MEA Benefits Trust. A request for assistance will generally be reviewed by the Board of Trustees at their next meeting. Upon completion of a review of the request for assistance, the Board of Trustees will, if they deem the circumstances to be appropriate, attempt to intervene on behalf of the participant. The decision of whether or not to intervene will take place as soon as possible following the receipt of the request for assistance.

Notwithstanding the foregoing, this request for assistance should not be construed as an additional level of claims appeal. A participant is not required to request assistance from the Board of Trustees before being deemed to have exhausted his or her administrative remedies under ERISA.

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

If your group health insurance, or your spouse or dependent group health insurance, ceases for any reason, you, your spouse or dependent may be able to elect continuation of your health insurance coverage under the COBRA. See the COBRA notice attached to this SPD.

ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits.
Examine, without charge, at the plan administrator's 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) and updated summary plan description. The administrator 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so 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 pension or a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights.
If your claim for a pension or welfare benefit is denied or ignored, 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 charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a 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 Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State of Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that 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 person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department

of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you are covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.
For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 (under 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."

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. When the qualifying event is 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), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events.

For the other qualifying events (divorce or other legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify Human Resources in writing within 60 days after the qualifying event occurs. You must provide the mailing address of the qualified beneficiary.

How is COBRA Continuation Coverage Provided?

Once the Human Resources 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 receive 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. To apply for the extension of your COBRA coverage due to a disability determination, you must contact the COBRA Administrator for the Plan (this is the organization to which you would be making your monthly COBRA premium payments). The COBRA Administrator will ask you to provide a copy of the disability determination letter from the Social Security Administration. The disability determination letter must include the date it was sent to you and the date of the disability. To be considered for the disability extension, you must send this information to the COBRA Administrator within 60 days of your receipt of the letter from Social Security and before the expiration of your 18-month COBRA coverage period. The COBRA Administrator will evaluate your request for the disability extension and provide a written response.

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, the 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 notice of the second qualifying event is properly given to the COBRA Administrator for the Plan (this is the organization to whom you would be making your monthly COBRA premium payments). This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the 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 the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. To apply for the extension of your COBRA coverage due to a second qualifying event, you must contact the COBRA Administrator for the Plan. The COBRA Administrator may ask you to provide documentation of the second qualifying event, including the date of the second event. You must notify the COBRA Administrator within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

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.

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 your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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 the EBSA website at 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**.

Keep Your Plan Informed of Address Changes.

To protect your family's rights, you should keep the Human Resources informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Human Resources.

Plan Contact Information.

If you have any questions about COBRA, please contact the Plan Administrator. Also, if you have changed marital status, or you or your spouse have changed addresses, please notify the Plan Administrator at the address listed in this Summary Plan Description.

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

NOTICE – Extension of Deadlines During the National Emergency Related to COVID-19

The DOL and IRS have issued COVID-19 related guidance that extends the following deadlines applicable to welfare plans and their participants and beneficiaries for the duration of the "Outbreak Period" (defined as the period starting March 1, 2020 and lasting until the earlier of: a) one year from the date the individual was first eligible for relief, or b) 60 days after the announcement of the end of the COVID-19 National Emergency, or such other date announced by the Agencies):

- *Claims and Appeals*: The deadline to file a claim or appeal in connection with an adverse benefit determination is suspended during the Outbreak Period. This extension applies to claims and appeals due on or after March 1, 2020, and suspends the applicable timelines for claims and appeals currently pending during the Outbreak Period.

- *HIPAA Special Enrollment*: The Outbreak Period is disregarded when determining the deadline by which an individual must request a HIPAA special enrollment. Under HIPAA, an individual generally has 30 days (60 days in certain cases) to request enrollment information in a group health plan following the occurrence of a HIPAA special enrollment event (*e.g.*, birth of a child, marriage, loss of other coverage).

- *Notice to the Plan of COBRA Qualifying Event or Disability*: The Outbreak Period is disregarded when determining the 60-day deadline for individuals to notify the plan of a COBRA-qualifying event (*e.g.*, divorce, legal separation, a child's loss of dependent status under the plan, or a disability determination by SSA).

NOTE: The deadline for employers to notify the plan of a qualifying event remains unchanged.

- *COBRA Election Period*: The Outbreak Period is disregarded when determining the 60-day deadline for individuals to elect COBRA continuation coverage as a result of experiencing a qualifying event.

- *COBRA Premium Payments*: COBRA requires an individual who enrolls in COBRA continuation coverage to make the initial premium payment required for the coverage within 45 days after the election, and plans must provide a grace period of at least 30 days for subsequent premium payments. The Outbreak Period is disregarded when determining the deadline to submit COBRA premium payments.

- *External Review*: The Outbreak Period is disregarded when determining the deadline for participants to file a request for external review after receiving an adverse benefit determination, or to submit information to perfect a request for external review during the Outbreak Period.