New York State Teamsters Council Health & Hospital Fund

Health Reimbursement Account Plan

Effective January 1, 2020

Your Funds……Working For You

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HEALTH REIMBURSEMENT ACCOUNT BENEFITS

The Health Reimbursement Account Plan is an Individual Account Plan ("HRA" or "Plan") within the New York State Teamsters Council Health & Hospital Fund ("Fund"). The Plan is administered by a Board of Trustees which has retained Lifetime Benefit Solutions, Inc. "Lifetime Benefits Solutions" or "Third-Party Administrator") to provide third-party administration services.

Capitalized terms found within this document are defined in Section 7 below.

SECTION 1

Health Reimbursement Accounts – In General

The Health Reimbursement Account Plan (HRA) is designed to help you purchase health insurance through the New York State Teamsters Council Health & Hospital Fund and to pay for certain medical costs not covered by the New York State Teamsters Council Health & Hospital Fund or any other health care or insurance plan.

When you become a Participant, an Individual Account will be established for you. Employer contributions will be made to your Individual Account based upon the terms of your employer's collective bargaining agreement and/or participation agreement with the Fund. Your HRA will grow through contributions that are made in the future and will decrease whenever there is a benefit distribution. You (or your spouse or dependents) will not receive any amount greater than what has been contributed into your Individual Account based on your work. Unused amounts in your HRA at the end of a Plan Year will be carried over to future Plan Years for the sole purpose of reimbursing you for Eligible Health Care Expenses (including premiums for the purchase of health insurance through the New York State Teamsters Council Health & Hospital Fund or other health insurance plan), also referred to as "Qualified Expenses".

Contributions received from your employer are held in trust by the Fund for the purpose of providing benefits to participants and beneficiaries.

Beginning January 1, 2014, you must actually be enrolled in the health insurance through the New York State Teamsters Council Health & Hospital Fund (or such other employer sponsored health plan that has been certified to the Plan Administrator as providing "minimum value," as such term is defined under the Affordable Care Act) in order to qualify to receive contributions to your individual account.

If you leave covered employment or do not enroll in the health insurance through the New York State Teamsters Council Health & Hospital Fund (or another employer-sponsored health plan

that provides "minimum value" as described above) as of January 1, 2014, you may continue to receive reimbursements from your individual account for so long as a balance is maintained in the account. However, utilization of benefits will be applicable to only those contributions made while you were covered under the health insurance offered through the New York State Teamsters Council Health & Hospital Fund (or such other employer-sponsored health plan providing "minimum value" as discussed above).

Upon your retirement, or permanent termination of service, on or after January 1, 2016, the remaining value of your account will be transferred to the New York State Teamsters Health & Hospital Fund Retiree and Former Employee Health Reimbursement Account Plan. You will continue to be able to access this account to pay qualified medical expenses, until your account is exhausted. The New York State Teamsters Health & Hospital Fund Reimbursement Retiree and Former Employee Account Plan is described in Appendix A to this Summary Plan Description.

Beginning January 1, 2017, the Qualified Expenses of your Eligible Dependents may only be reimbursed if your Eligible Dependents were enrolled in group medical coverage at the time such expenses were incurred.

SECTION 2

Eligible Expenses

You can use your HRA funds to pay for Eligible Health Care Expenses incurred by you, your spouse, or your dependents, including premiums for the purchase of health insurance coverage through the New York State Teamsters Council Health & Hospital Fund or other employer provided group health insurance plan, including COBRA premiums. You **may not** use your HRA funds to pay for premiums for individual market health insurance coverage.

Eligible Health Care Expenses include, but are not limited to, charges by any doctor, dentist, optometrist, ophthalmologist, hospital, long-term care facility or other health facility, pharmacy, optical dispensing service, or hearing aid provider that are not covered by any health plan under which you are covered. You must have a prescription from your health care provider in order to be reimbursed for over-the-counter (OTC) medications (excluding insulin).

Upon receipt of a written request and authorization, the Fund or the Third-Party Administrator will withdraw from your Individual Account the monies necessary for you to purchase health insurance coverage offered by the New York State Teamsters Council Health & Hospital Funds.

You may be reimbursed only for premiums to purchase group health insurance and uninsured health-related expenses incurred by you, your spouse or your dependents on or after September 1, 2012, the effective date of this Plan. Please note that no health-related expenses may be reimbursed under the Plan unless they qualify as medical expense deductions under Internal Revenue Code Section 213(d). (Contact the IRS for its Publication 502 which has a comprehensive listing of these expenses; or, visit www.irs.gov. You may also contact the Fund Office or Lifetime Benefit Solutions, the Third-Party Administrator, for a list of Eligible Health Care Expenses). In addition, you may not receive a reimbursement for any medical expense that

you have taken as a deduction on your income tax return or for any medical expense which is eligible under another health care plan.

If you die and still have a balance remaining in your HRA, your spouse and other eligible dependents may continue to apply for reimbursements of health-related expenses under the Plan and use the account for payment of health insurance premiums. If you die and do not have a spouse or any other eligible dependents, any balance remaining in your HRA will be forfeited.

SECTION 3

Debit Card Program

The Plan will provide you with a Debit Card to use to pay for your medical expenses. You must complete certain administrative forms and comply with other procedures established by the Trustees and the Third-Party Administrator for use of the Debit Card. The Debit Card may be used to pay for certain Eligible Health Care Expenses as defined in Internal Revenue Code Section 213(d) paid by you or your eligible dependent after all insurance reimbursement has been received. You must certify in writing that, at the time of your enrollment in the Debit Card Program and in the Cardholder Agreement, (i) the Debit Card will only be used for Qualified Expenses; (ii) any expense paid with the Debit Card has not been reimbursed; (iii) you will not seek reimbursement under any other plan covering health benefits; and (iv) you will reimburse the Plan for the amount of any transaction that was not for a Qualified Expense. This certification, which was included with your debit card, and has an affirmation on the back of each debit card is reaffirmed every time the Debit Card is used.

You may use the Debit Card as long as you remain eligible for benefits under the HRA, provided you comply with the applicable requirements of the Plan and the Debit Card Program. Such Debit Card shall be automatically cancelled upon your death. Debit cards are reissued every three years.

The dollar amount available on the Debit Card shall be the total amount in your HRA. The maximum dollar amount of any one transaction using the Debit Card cannot exceed five thousand dollars ($5,000). The maximum allowed per 24 hour period is ten thousand dollars ($10,000). In no event may any transaction using the Debit Card exceed the balance in your account.

The Debit Card may only be used at eligible medical, dental and vision providers and pharmacies and merchants that participate in the "inventory information approval systems" described in IRS Notice 2006-69, as modified by IRS Notice 2007-2, including any subsequent IRS guidance.

Generally, Qualified Expenses are automatically deducted from your HRA account, provided, however, an "authorization" through the Debit Card Program is required for processing most transactions. A transaction will be authorized only if there are funds available in your HRA. Authorization may be denied if:

(i) the transaction amount exceeds available funds in your HRA;

(ii) the Trustees or the Third-Party Administrator believes that the proposed transaction is not for a Qualified Expense, or

(iii) the transaction amount exceeds the limit for a single transaction (i.e., $5,000) or the maximum amount allowed per 24 hour period (i.e. $10,000).

Debit Card transactions are subject to substantiation. Therefore, you must save receipts and documentation relating to any transactions made with your Debit Card and you must present them to the Plan upon request. The Third-Party Administrator or the Plan may make a written request to you for submission of receipts and supporting documentation from a merchant or service provider describing the service or product, the date of the purchase and the paid amount. Certain Debit Card charges may be considered by the Third-Party Administrator or the Fund as substantiated at the time of charge by the nature of the charge, such as copayments. Some charges shall be considered substantiated due to their "recurring" nature, in which the expenses match expenses previously approved as to amount, provider, and time period. All other Debit Card charges shall be treated as conditional pending written confirmation and substantiation from you.

If a Debit Card purchase is determined by the Trustees or the Third-Party Administrator to not be a Qualified Expense, the Third-Party Administrator shall take the steps listed below to obtain repayment of the amount of such non-qualified expense:

(i) You will be directed in writing by the Third-Party Administrator to supply receipts for all transactions that were not substantiated automatically.

(ii) The Third-Party Administrator will provide a notice to you providing that you are required to repay the Fund in an amount equal to the improper payment.

(iii) Where your repayment is not timely made, the Plan will turn off your debit card and we will withhold future claim payments to you and your eligible dependents related to such account until the indebtedness is repaid.

For transactions determined by the Plan or Third-Party Administrator to be for Non-Qualified Expenses ("NQE"), you will automatically be notified of a balance due on the Third-Party Administrator's website and will be sent a communication via postal mail informing you of the amount due. The Third-Party Administrator reserves the right to impose a service charge for the processing of each NQE transaction and it will provide notice to you if it charges such fee. If you do not repay an amount due under the Plan by the requested deadline, the Debit Card may be suspended. The Third-Party Administrator will work with the Plan to recoup any balance due from you to the Plan for the reimbursement of any such NQE.

A Debit Card may be suspended or cancelled at any time at the discretion of the issuing bank or by the Trustees of the Plan.

You must report to the Plan and the Third-Party Administrator any unauthorized use of the Debit Card and any lost or stolen Debit Card within five (5) days after information concerning the unauthorized use, lost or stolen Debit Card is available to you. Failure to report may make you responsible to reimburse the Plan for the unauthorized use of the Debit Card.

SECTION 4

Submitting Claims

If you do not use the Debit Card, you must submit HRA claims to the Third-Party Administrator on the form that they will provide and include any documentation that the Third-Party Administrator requires. Each claim for reimbursement must include itemized bills for Eligible Health Care Expenses that have already been paid. In order to be eligible for reimbursement, health-related expenses must have been incurred by you, your spouse or other eligible dependents within 24 months prior to the date on which you submit your claim. The minimum claim filed must be at least $30 of out-of-pocket expense and you may add several bills together to arrive at the $30 minimum. However, there is no minimum amount for debit card payments. If you submit multiple claims to the Third-Party Administrator, they will be processed in the order in which they are received. Claims under this benefit will be paid by Lifetime Benefit Solutions on a weekly basis. Claims should be submitted to the Third-Party Administrator at the following address:

Lifetime Benefit Solutions, Inc.
P.O. Box 6509
Syracuse, New York 13217
Telephone: 1-800-327-7130
Website: www.LifetimeBenefitSolutions.com

SECTION 5

Account Forfeitures

If no contributions into or distributions from the account have occurred within the preceding twenty-four (24) months and your account balance is less than $500, your (or your survivor(s)') account will be closed and the balance of your account forfeited.

SECTION 6

Eligibility

An employee must work one or more hours for which contributions are made to the Fund on his or her behalf. Once this has occurred, you will be a Participant in the Plan. Your legal spouse and children may also be eligible to participate in the Plan provided they qualify as Eligible Dependents. You and your Eligible Dependents may be entitled to continue to participate in the plan when you are on Family and Medical Leave , New York Paid Family Leave, or you are called to Military Service.

You also annually have the right to permanently opt-out of and waive all future reimbursements from your individual account. If you are continuing to work in covered employment, this means

that you will be choosing to forego your benefits despite the fact that contributions will continue to be made to the Fund on your behalf. Depending on the amount of work you perform in covered employment, choosing to permanently forego this coverage could result in adverse financial and tax consequences for you and your family. Thus, you should carefully consider the consequences of permanently opting to forego your benefits, and should discuss any such decision with a qualified tax professional.

On the other hand, if you have ceased work in covered employment (or your hours have been reduced) and you no longer qualify for the health insurance coverage offered through the New York State Teamsters Council Health & Hospital Fund, you may be eligible to qualify for a premium tax credit for coverage purchased through the exchange Marketplace if you elect to waive your individual account balance. However, you should also note that any remaining balance in your individual account may be exhausted by purchasing COBRA Continuation Coverage through the New York State Teamsters Council Health & Hospital Fund. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. More information about the Health Insurance Marketplace generally is available at: www.HealthCare.gov. If you would like more information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence. You should carefully research all of your options prior to making any decision to opt-out of the Health Reimbursement Account Plan.

If you would like to opt-out of the Health Reimbursement Account Plan, you should contact the Plan Administrator.

Please Note:

You must immediately notify the Fund or the Third-Party Administrator when you gain a dependent or when your dependent no longer qualifies for coverage. You are responsible for providing the Fund with the required certified copies of birth certificates, marriage certificates, divorce decrees, or any other documentation the Fund may require. This information must be received by the Fund within ninety (90) days from the date that you or your dependent is eligible for coverage. If the information is not received within this period, benefits for you or your dependent will not be effective until the first of the month in which the information is finally received. Additionally, within sixty (60) days of the event, you must notify the Plan when your dependent is no longer eligible for coverage.

SECTION 7

Definitions

The following are definitions of certain important terms appearing within this booklet:

Eligible Dependents - "Eligible Dependents" means the following dependents who meet the Fund's eligibility requirements are covered:

1. Your legal spouse.

2. Eligible Children**.** Children (including biological children, adopted children, children placed for adoption, stepchildren, foster children, including a grandchild who has been placed with you by a court of competent jurisdiction) are eligible for the Plan's coverage until attainment of age 26 regardless of whether they are married, are full-time students, or whether the Participant is primarily responsible for their support. Children named in a Qualified Medical Child Support Order which meets the requirements of ERISA as described below, are also eligible dependents for purposes of the Plan's coverage. Permanently and totally disabled children of the Participant will continue to be covered past age 26 for as long as they remain permanently and totally disabled as described below.

   Permanently and Totally Disabled. To be considered permanently and totally disabled, your child must be incapable of working because of mental illness, developmental disability, or mental retardation, (as defined in the New York State Mental Hygiene Law) or a physical handicap. This condition must have occurred **before** the dependent reached age twenty six (26), or while he or she was otherwise eligible as a dependent under this program.

   The Plan's definition of eligible children is meant to be consistent with IRS rules.

Important: Certified birth certificates, certified divorce decrees, and tax returns as appropriate must be submitted to the Fund Office at the time of enrollment.

You may be required to submit periodic medical evidence to support the continuation of coverage.

Eligible Health Care Expenses - "Eligible Health Care Expenses" or "Qualified Expenses" means certain out-of-pocket (such as medical, dental, and vision) expenses which are incurred by you and your dependents as well as premiums for health insurance coverage. Such expenses must be permitted by Section 213 of the Internal Revenue Code to be considered "Eligible Health Care Expenses" under the Plan. A list of some of the expenses that qualify is available from the Third-Party Administrator.

Family and Medical Leave - Under the Family and Medical Leave Act (FMLA), you may qualify for benefits during a period you are on leave for the purposes described in the Act. For more information concerning the FMLA, you may contact the Third-Party Administrator or the Fund.

Fund - "Fund" means the New York State Teamsters Council Health & Hospital Fund.

Individual Account - "Individual Account" means an account established to receive employer contributions on behalf of each Participant pursuant to the provisions of this Plan.

Military Service - When a Participant leaves employment for full-time military service, as defined by Federal Law, the Participant and his or her eligible dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under Federal Law. You may contact the Third-Party Administrator or the Fund for more information.

New York Paid Family Leave - You may qualify for benefits during a period you are on leave for the purposes described in the New York Paid Family Leave Benefits Law. For more information concerning the New York Paid Family Benefits Law, you may contact the Third-Party Administrator or the Fund.

Non-Qualified Expenses - "Non-Qualified Expenses" means expenses which are incurred by you and your dependents that are not permitted by Section 213 of the Internal Revenue Code. A list of some of the expenses that do not qualify is available from the Third-Party Administrator.

Participant - "Participant" means an individual that has met the eligibility requirements of the Plan and for whom an Individual Account has been established.

Plan or HRA - "Plan" or "HRA" means this Health Reimbursement Account Plan.

Plan Year - "Plan Year" means the fiscal year of the Plan, constituting the twelve month period beginning January 1 and ending December 31.

Qualified Expenses – "Qualified Expenses" or "Eligible Health Care Expenses" for active employees means certain out-of-pocket (such as medical, dental, and vision) expenses which are incurred by you and your dependents as well as premiums for group health insurance coverage. With the exception of individual market health insurance premiums, the expenses which qualify are those permitted by Section 213 of the Internal Revenue Code. A list of some of the expenses that qualify is available from the Third-Party Administrator. For participants in the Retiree and Former Employee Health Reimbursement Account Plan, "Qualified Expenses" or "Eligible Health Care Expenses" also include premiums for individual health insurance policies.

Qualifying Event - "Qualifying Event" means an event (such as termination of employment, divorce or the death of an employee) that triggers eligibility for COBRA coverage.

Qualified Medical Child Support Order - The Omnibus Budget Reconciliation Act of 1993 requires health plan Third-Party Administrators to recognize qualified medical child support orders ("QMCSOs"). A QMCSO is a decree or judgment from a court or administrative agency which mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled to enrollment in a parent's group health plan as "alternate recipients." Both you and your beneficiaries can obtain, upon request and without charge, a copy of the Plan's procedures concerning Qualified Medical Child Support Orders (QMCSOs).

Upon receipt of a Medical Child Support Order, the Third-Party Administrator will promptly notify the Participant and each child of receipt of the Order. The Participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be considered a dependent under the Plan for benefits purposes and a Participant for notification purposes, which means the child will receive copies of Summary Plan Descriptions, Summary Annual Reports, and summaries of any amendments made to the Plan according to current ERISA requirements. When the Fund receives such an Order, it will automatically make any necessary changes in the coverage the Participant has selected to include his or her dependent

child(ren). The Participant will be required to complete and provide such documentation as may be necessary.

Third-Party Administrator - "Third-Party Administrator" means an individual or firm hired by the Plan to handle claims processing and manage other functions related to the operation of the HRA.

SECTION 8

Claims and Appeals

Initial Decisions

Time Frames

Claims under this Plan will be paid as soon as is practicable following the submission of your claim. You will be notified of any adverse benefit determination by the Third-Party Administrator within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended for up to 15 days due to extenuating circumstances if, before the end of the initial 30-day period, the plan notifies you of the reasons for the extension and of the date by which it expects to render a decision. If the Third-Party Administrator determines that you did not submit the information necessary to decide the claim, you will receive written notice that describes the required information and will be given at least 45 days from receipt of the notice to provide it**.** Your claim will not be processed unless you provide the Third-Party Administrator with all information that it informs you is necessary to decide the claim. Once the Third-Party Administrator receives all such information, it will respond to the claim within the time periods described above.

Content of Notification of Initial Adverse Benefit Determination

In an initial notification of adverse benefit determination, the notification shall set forth the following:

1. The specific reasons for the adverse determination;

2. Reference to the specific Plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;

3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

4. A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;

5. If an internal rule, guideline, or protocol or other similar criterion was relied upon in making the adverse determination, the notice will provide either the specific rule, guideline, protocol or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such file, guideline, protocol or other criterion will be provided free of charge upon request; and

6. If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the determination, applying the Plan's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

Appeals of Adverse Benefit Determinations

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal to the Board of Trustees. To appeal an adverse benefit determination, you must write to the Board of Trustees within 180 days after you receive this Plan's initial determination.

If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such statement. Your correspondence, or your representative's correspondence, must include the following statement: "I AM WRITING IN ORDER TO APPEAL THE DECISION TO DENY ME BENEFITS. THE ADVERSE BENEFIT DETERMINATION WAS DATED _____." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general inquiry.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by at least two members of the Board of Trustees; (2) insofar as the adverse benefit determination is based on medical judgment, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the adverse benefit determination.

Determinations on Appeal

Time Frames

The Board of Trustees at their next regularly scheduled meeting will make a determination on the appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Board of Trustees will notify you, or your authorized representative, of the benefit determination not later than 5 days after the determination is made.

Content of Adverse Benefit Determination on Review

The Plan's written notice of the Board's decision will include the following:

1. The specific reasons for the adverse benefit determination;

2. Reference to specific plan provisions on which the determination is based;

3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

4. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain 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 upon request.

The Trustees' Decision is Final and Binding

The Board of Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. The Board of Trustees' decision with respect to their review of your appeal will be final and binding. Any legal action against this Plan must be started within one (1) year from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

Effective for claims filed on or after April 1, 2018, the following applies to any benefit determination conditioned on a finding of disability by the Plan. These rules do not apply to a

determination conditioned on a finding of disability by a party other than the Plan (e.g. the Social Security Administration).

1. Adverse benefit determination notices will include the following:

    a. Discussion of the decision including, if applicable, an explanation of the basis for disagreeing with or not following:

        (i) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

        (ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

        (iii) A Social Security Administration disability determination regarding the claimant, presented by the claimant to the Plan.

    b. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

    c. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

    d. For appeal determinations, any contractual limitations period for filing a civil action and the calendar date deadline for doing so.

2. Before the Plan issues an adverse benefit determination on appeal, the Plan Administrator will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Trustees, or their designee, (or at the direction of the Trustees or their designee) in connection with the claim.

3. Before the Plan issues an adverse benefit determination on appeal based on a new or additional rationale, the Plan Administrator shall provide the claimant, free of charge, with the rationale.

4. The term ''adverse benefit determination'' also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term ''rescission'' means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

5. To the extent required by applicable law, any notices will be provided in a culturally and linguistically appropriate manner.

6. To the extent the Plan violates any applicable claims and appeals procedures, a participant may request a written explanation of the violation from the Plan. The Plan will respond within ten days.

SECTION 9

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop. The paragraphs below generally explain 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.

Qualifying Events

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of coverage due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of this Plan due to a reduction in hours worked, including a strike, walkout or layoff, or a loss of eligibility due to reduction of Individual Account. ***You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account. You will continue to have access to your Individual Account and to receive reimbursements from your Individual Account so long as the account balance is sufficient to cover your claims and exceeds the minimum required account balance. In fact, your Individual Account can be used to pay the required COBRA premiums for health insurance benefits***.

Spousal Eligibility for COBRA Coverage

Your spouse may elect COBRA continuation coverage upon the loss of coverage due to the occurrence of any of the following Qualifying Events:

1. Your death.

2. Your spouse's loss of coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of this Plan due to a reduction in hours worked including a strike, walkout or layoff, or a loss of eligibility due to a reduction of Individual Account.

3. Divorce or judicial order of legal separation.

4. Your enrollment in Part A or Part B of Medicare.

If your spouse has a COBRA Qualifying Event as a result of your death, your enrollment in Part A or Part B of Medicare, your termination from covered employment or a reduction of your hours of covered employment, then your spouse is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account. Your spouse will continue to have access to your Individual Account and to receive reimbursements from your Individual Account so long as the account balance is sufficient to cover the claims.

In the event your spouse has a COBRA Qualifying Event as a result of divorce or judicial order of legal separation, to continue to have access to your Individual Account and to receive reimbursements from your Individual Account your spouse MUST elect COBRA continuation coverage and pay COBRA premiums.

Dependent Eligibility for COBRA Coverage

Your dependent children can elect COBRA continuation coverage upon the loss of coverage due to the occurrence of any of the following Qualifying Events:

1. Your death.

2. Your dependent child's loss of coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of this Plan due to a reduction in hours worked including a strike, walkout or layoff , or a loss of eligibility due to a reduction of Individual Account.

3. Divorce or judicial order of legal separation of the child's parents.

4. Your enrollment in Part A or Part B of Medicare.

5. The child ceases to qualify as an "eligible dependent" as described in Article II.

If your dependent child has a COBRA Qualifying Event as a result of your death, your enrollment in Part A or Part B of Medicare, your termination from covered employment or a reduction of your hours of covered employment, then your dependent child is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account. Your dependent child will continue to have access to your Individual Account and to receive reimbursements from your Individual Account so long as the account balance is sufficient to cover the claims.

In the event your dependent child has a COBRA Qualifying Event as a result of your divorce or judicial order of legal separation or because your child ceases to qualify as an "eligible" dependent, to continue to have access to your Individual Account and to receive reimbursements from your Individual Account your dependent child MUST elect COBRA continuation coverage and pay COBRA premiums.

If, while you are receiving COBRA continuation coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your coverage. You must, however, notify the Third-Party Administrator immediately of such a change.

Notifications to the Fund Office

Your employer has the obligation to notify the Third-Party Administrator of your death or your enrollment in Part A or Part B of Medicare. The Trustees have determined that, because employees frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

You have the responsibility to inform the Third-Party Administrator using the Plan's "Participant's Notice to Third-Party Administrator" form which can be obtained from the Third-Party Administrator of a divorce, a judicial order of legal separation, a child's loss of status as an eligible dependent, the birth or adoption of a dependent, or a determination by the Social Security Administration that a qualified beneficiary is disabled. This notice must be given within 60 days after the occurrence of the Qualifying Event or the date coverage would be lost because of the Qualifying Event, whichever is later. Failure to give notice to the Third-Party Administrator within the time limits may result in your ineligibility for COBRA continuation coverage.

In addition to giving notice of certain Qualifying Events, you have the responsibility to inform the Third-Party Administrator in the event that the Social Security Administration has determined you or one of your qualified beneficiaries to no longer be disabled. This notification must be made within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

Notification of COBRA Rights

After the Third-Party Administrator receives notice of the occurrence of one of the above Qualifying Events, the Third-Party Administrator will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Third-Party Administrator will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the Qualifying Events described above or after it has determined that your regular group health care coverage has terminated.

Election of COBRA Coverage

The employee, spouse and dependent children each have independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have 60 days from the date he or she would lose coverage because of one of the Qualifying Events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Third-Party Administrator that he or she wants COBRA continuation coverage. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60 day period described above as

long as the completed COBRA Election Form, if mailed, is post-marked no later than the due date. If the election is hand-delivered, the date of delivery must be on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form, if mailed, is post-marked. If the election is hand-delivered, your COBRA continuation coverage will begin on the date of delivery.

You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account. You will continue to have access to your Individual Account and to receive reimbursements from your individual account so long as the account balance is sufficient to cover your claims. In fact, your Individual Account can be used to pay the required COBRA premiums for health insurance benefits.

Benefits Provided Under COBRA Coverage

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the Qualifying Event making the individual eligible for COBRA continuation coverage. However, no life insurance (death benefits) or disability benefits or accidental death and dismemberment benefits or other non-health benefits will be included.

Consequences of Failing to Elect or Waive COBRA Continuation Coverage

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Duration and Termination of COBRA Coverage

If the election is due to termination of your employment or a reduction in hours worked, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, each of you can receive a total of 29 months of COBRA continuation coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. Your employer no longer provides group health coverage.

2. Failure to pay the monthly premium on time.

3. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions ***(note: there are limitations on***

plans imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).

4. The individual enrolls in Part A or Part B of Medicare.

5. Circumstances are such that the individual's participation could be canceled if the individual were an active employee, such as submitting fraudulent claims or claiming ineligible dependents.

If any of these events occur, the Third-Party Administrator will send you a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the employee, spouse or dependent child may have under the Plan to elect alternate coverage.

Cost and Payment of COBRA Coverage

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The first payment must be made within 45 days of the date written election of coverage is made. After the first payment is made, future payments must be made within thirty (30) days after the first day of the month.

The monthly premium will be based on the average cost which the Plan incurs annually per employee, as determined by the Trustees, plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled Participants are at a monthly charge based on one and one-half times the average annual per Participant cost incurred by the Plan.

Additional Information about COBRA Coverage

COBRA continuation coverage is described in greater detail in a letter sent out by the Plan to each Participant when the Participant becomes eligible to participate in the Plan or when COBRA first became applicable to the Plan, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Fund Office.

Keep your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Third-Party Administrator informed if any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Third-Party Administrator.

SECTION 10

HIPAA Confidentiality of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and amendments made by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") the Fund is required to protect the privacy of your individually identifiable

health information (referred to here as "protected health information" or "PHI"). HIPAA permits the Fund to make certain types of uses and disclosures of PHI for treatment, payment and health care operations purposes:

For treatment purposes, such use and disclosure will take place in providing, coordinating or managing health care and its related services by one or more of your providers, such as when your primary care physician consults with a specialist regarding your condition;

For payment purposes, such use and disclosure will take place to obtain premiums or to determine responsibility for coverage and benefits, such as if the Fund confers with insurers to resolve a Coordination of Benefits issue or to obtain or provide reimbursement for providing health care, such as when your case is reviewed to ensure that appropriate care was rendered;

For health care operations purposes, such use and disclosure will take place in a number of ways, including for quality assessment and improvement, provider review and training, underwriting activities, reviews and compliance activities, planning and development, management and Fund administration. Your information could be used, for example, to monitor the quality of care provided under the Fund or to audit the Fund. In addition, the Fund may contact you to provide information about other health related benefits and services that may be of interest to you; and disclose your PHI to the Board of Trustees, as described in the Plan Document.

The Fund may use and disclose your PHI, **without your authorization,** as follows:

- As required by law;
- For public health activities;
- To report victims of abuse, neglect or domestic violence;
- For health oversight activities;
- For judicial and administrative proceedings;
- For law enforcement purposes and to report a crime;
- To permit authorized organ donations;
- For valid research purposes;
- To avert a serious threat to health or safety; and
- For a specialized government function involving the military and veterans activities, national security, protective services for the President, correctional facilities, law enforcement custodial situations, and government programs providing public benefits.

Anyone requesting a disclosure of your PHI in the absence of your specific authorization will be required to provide reasonable proof to the Fund that the requested disclosure is for one of these permitted purposes under the law.

Other uses and disclosures will be made only with your written authorization. You may revoke your authorization by notifying the Fund in writing to the address below. If you do so, the Fund will not use or disclose your PHI authorized by the revoked authorization, except to the extent that the Fund already has relied on your authorization.

Once your PHI has been disclosed pursuant to your authorization, the federal privacy protections may no longer apply to the disclosed information, and that information may be re-disclosed by the recipient without your or the Fund's knowledge or authorization.

You may ask the Fund to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Fund is not required to agree with your request.

Unless you object in writing, the Fund may disclose PHI to one of your family members, to a relative, a close personal friend or to any other person identified by you in writing, if it is directly relevant to the person's involvement with your care or payment related to your care. In addition, unless you object in writing by sending a letter to the Fund's HIPAA Privacy Officer, the Fund may use or disclose the PHI to notify, identify or locate a member of your family, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency or you otherwise do not have the opportunity to object to this use or disclosure, the Fund will do what in its judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your health care. The Fund does not contemplate that there will be routine situations where personnel you have not authorized will present themselves as persons involved in your health care or request your PHI from the Fund. The Fund will use its reasonable judgment to respond to basic questions about coverage and eligibility and appeals made on your behalf by persons involved in your health care unless specifically directed by you not to provide such information.

The Fund cannot recognize a person as a personal representative if:

- The covered individual is an unemancipated minor receiving a health care service that permits the minor to consent to receive and the minor has not designated a personal representative; or

- The minor may lawfully obtain the service without parental consent and a lawful consent has been obtained; or

- The parent has agreed to confidentiality between the minor and the Fund; or

- The Fund has a reasonable belief that the individual has been or may be subject to domestic violence or may otherwise be endangered;

- The Fund determines recognizing the personal representative is not in the individual's best interest; or

- If the individual is not a minor, the personal representative must provide the Plan with official documentation appointing him/her as the personal representative, such as a court order.

The term "parent" includes a legal guardian or other person acting in the place of the parent under the laws of the State of New York.

You have the right to request the following with respect to your PHI:

(i) inspection and copying; (ii) amendment or correction; (iii) an accounting of the disclosures of this PHI by the Fund; and (iv) the right to receive a paper copy of the Fund's Privacy Notice upon request. You must write to the Fund's HIPAA Privacy Officer describing in detail the specific items requested, namely: (i), (ii) and/or (iii), above.

The Fund reserves the right to change the terms of its Privacy Notice and to make the new Privacy Notice provisions effective for all PHI the Fund maintains. Revisions to the terms of the Privacy Notice will be sent to you by United States mail.

If you believe that your privacy rights have been violated by the Fund, you may complain in writing to the Fund by sending a letter addressed to HIPAA Privacy Officer at the address below, or to the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

For further information regarding HIPAA, you may contact the Fund as follows:

Kenneth R. Stilwell, Executive Administrator and HIPAA Privacy Officer
New York State Teamsters Council Health and Hospital Fund
151 Northern Concourse
P.O. Box 4928
Syracuse, New York 13221-4928

SECTION 11

Plan Interpretations and Determinations

The Board of Trustees are responsible for interpreting this Plan and for making determinations under this Plan as well as for controlling and managing the operation and administration of the Plan in accordance with the provisions of this Plan and the Agreement and Declaration of Trust. The Board of Trustees may, as they deem appropriate or necessary in their sole discretion, delegate to persons who are not members of the Board of Trustees, such as the Third-Party Administrator, any of its administrative duties and fiduciary responsibilities under this Plan and the Agreement and Declaration of Trust. In order to carry out its responsibilities, the Board of Trustees or their designee shall have exclusive authority and discretion to determine all questions arising in the administration of the Plan which shall include the authority and discretion to: (1) determine whether an individual is eligible to receive benefits under this Plan; (2) to calculate the amount of benefits, if any, an individual is entitled to receive from this Plan; (3) interpret and apply all of this Plan's provisions; and (4) construe all of the terms used in this Plan. All determinations and interpretations made by the Board of Trustees, or their designee, shall be final and binding upon any individual claiming benefits from this Plan. Any such determinations and interpretations shall be given deference in all courts of law, to the greatest extent allowed by the applicable law and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious, or made in bad faith. All determinations by the Board of Trustees or their designee shall be based upon the criteria set forth in this Plan.

The Trustees reserve the right to amend, modify or terminate any and all Plan benefits at any time and for any reason and with or without notice.

No employer, shop steward, union representative, or union employee is authorized to interpret the Plan or booklet.

SECTION 12

General Information and ERISA Rights

General Information

The following information is provided as specified in Section 102 (b) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"):

1. **Official Name of Plan.** New York State Teamsters Council Health and Hospital Fund.

2. **Type of Plan and Administration.** The Plan is a Welfare Plan providing certain health benefits. The Plan is administered and maintained by a joint Board of Trustees, four of whom are appointed by sponsoring labor unions and four of whom are appointed by sponsoring employers. The Trustees employ an Executive Administrator and office staff to keep records and make certain benefit payments. Likewise, the Trustees employ certain Third-Party Administrators to process benefit claims under separate agreements. The Plan is maintained pursuant to Collective Bargaining Agreements and Participation Agreements between participating employers and Local Unions. Copies of such agreements may be obtained upon written request to the Executive Administrator.

3. **Executive Administrator.** The name of the Executive Administrator, who is located at the Fund Office, is as follows:

   Kenneth R. Stilwell, Executive Administrator
   New York State Teamsters Council Health and Hospital Fund
   151 Northern Concourse
   P.O. Box 4928
   Syracuse, New York 13221-4928

4. **Official Plan Administrator and Named Fiduciary.** The Board of Trustees, which is the Official Plan Administrator and Named Fiduciary, has been designated as agent for the service of legal process, as well as, the Executive Administrator. The Board of Trustees and the Executive Administrator both may be served with legal process at the above-address of the Executive Administrator. Service of process may also be made upon a Trustee. **The names and addresses of the Trustees are:**

LABOR TRUSTEES

John A. Bulgaro, Co-Chairman
Teamsters Local Union No. 294
Labor Temple
890 Third Street
Albany, New York 12206-1632

Mark D. May
Teamsters Local Union No. 317
P.O. Box 11037
Franklin Square Station
Syracuse, New York 13218-1037

Brian K. Hammond
Teamsters Local Union No. 687
14 Elm Street
Potsdam, New York 13676

George Harrigan
Teamsters Local Union No. 449
2175 William Street
Buffalo, New York 14206

EMPLOYER TRUSTEES

Michael S. Scalzo, Sr., Co-Chairman
ABF Freight System, Inc.
7 Depot Hill Road
Enfield, Connecticut 06082

Mark Gladfelter
YRC Worldwide
100 Roadway Drive
Carlisle, Pennsylvania 17015

Daniel W. Schmidt
New Penn Motor Express
625 South 5th Avenue
Lebanon, Pennsylvania 17042-0630

Samuel Pilger
Transport Employers Association
700 South Waverly Road
Holland, Michigan 49424

5. **Source of Financing.** Payments are made to the New York State Teamsters Council Health & Hospital Fund by individual employers under Collective Bargaining Agreement and/or participation agreement provisions. All moneys are used exclusively for providing benefits to eligible employees or their dependents, and the payment of all expenses incurred with respect to the operation of the Plan. The Trustees employ professional advisors, including:

LEGAL COUNSEL

Blitman & King LLP
Franklin Center, Suite 300
443 North Franklin Street
Syracuse, New York 13204-5412

Morgan, Lewis & Bockius LLP
1111 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Paravati, Karl, Green and De Bella
12 Steuben Park
Utica, New York 13501-2992

AUDITOR

D'Arcangelo & Company
120 Lomond Court
Utica, New York 13502

INVESTMENT ADVISOR

Meketa Investment Group, Inc.
100 Lowder Brook Drive
Suite 1100
Westwood, Massachusetts 02090

ACTUARY/CONSULTANT

Solid Benefit Guidance, LLC
228 Rivervale Road
River Vale, New Jersey 07675-6216

The Fund Office will provide you, upon written request, with information as to whether an employer is contributing to the Plan on behalf of any of its employees, and if so, the employer's address.

Health Reimbursement Account Benefits are self-funded and administered by:

Lifetime Benefit Solutions, Inc.
P.O. Box 6509
Syracuse, New York 13217
1-800-327-7130
www.LifeTimeBenefitSolutions.com

6. **Plan Year.** The Plan Year ends on December 31.

7. **Internal Revenue Service Plan Identification No.** 15-0551885

8. **Plan Number.** 501

9. **Plan Termination and Amendment.** The Trustees intend to continue the Plan as described in this booklet indefinitely. Nevertheless, they reserve the right to terminate or amend the Plan by resolution adopted in accordance with the Plan's Trust Agreement. The Plan will terminate if there is no longer an agreement in effect between any employers and Local Unions requiring contributions to the Plan.

   The Trustees reserve the right to amend the eligibility rules at the time of termination. In any case, the Trustees shall use any remaining assets of the Plan

to provide benefits and pay administration expenses or otherwise carry out the purpose of the Plan in an equitable manner until all assets have been disbursed.

10. **Vesting.** No vested or accrued right to coverage shall be deemed to have arisen because it is part of this benefits program at this time, and there shall not be deemed to be a contractual or other right to receive coverage as a consequence of your status as a present or past employee.

11. **Governing Law.** The Plan is governed by ERISA and New York State law, to the extent not preempted by ERISA.

ERISA Rights

The following statement of your rights under ERISA is furnished in compliance with ERISA Section 104 (c).

As a Participant in the New York State Teamsters Council Health &Hospital Fund, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan Participants shall be entitled to:

1. **Examine,** without charge, at the Executive Administrator's office all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U. S. Department of Labor, such as detailed Annual Reports and Summary Plan Descriptions.

2. **Obtain copies** of all documents and other plan information upon written request to the Plan Administrator. The Executive Administrator, on behalf of the Plan, may make a reasonable charge for the copies.

3. **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.

In addition to creating rights for plan Participants, ERISA imposes duties upon people who are responsible for the operation of the Plan. The people who operate your Plan are called "fiduciaries" and have a duty to operate the Plan 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 benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. This booklet details the applicable claims and appeals procedures.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan and do not receive them within thirty **(30)** days, you may file a suit in 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or 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 you believe that the Plan fiduciaries have misused the Plan's money or that you have been 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.

If you have any questions about your Plan, you should contact the Executive 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 (EBSA), U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration.

APPENDIX A

Retiree and Former Employee Health Reimbursement Account Plan

Upon retirement, or other permanent termination of service on or after January 1, 2016, a retiree's or former participant's HRA will be transferred to this Retiree and Former Employee HRA Plan. Once you become a participant in the Retiree and Former Employee Health Reimbursement Account Plan, you may use your account for the reimbursement of Eligible Health Care Expenses incurred by you, your spouse, or your eligible dependents. Eligible Health Care Expenses include those expenses defined in Section 213(d) of the Internal Revenue Code (as described in IRS Publication 502). You can find a copy of this publication on www.irs.gov, or you may contact the Fund Office or the Plan's Third-Party Administrator, Lifetime Benefits Solutions, for a listing of Eligible Health Care Expenses.

The rules for providing documentation of a claimed expense or using your HRA debit card are the same as under the HRA Plan for active employees. These rules are discussed in detail in Sections 3 and 4 of the Summary Plan Description.

Your Eligible Dependents include your legal spouse and your biological, adopted, step, or foster children (including a grandchild who has been placed with you by a court of competent jurisdiction) who are under the age of 26 or who are over the age of 26 and permanently and totally disabled. In order to be considered permanently and totally disable, your child must be incapable of working because of mental illness, developmental disability, or mental retardation (as defined in the New York State Mental Hygiene Law) or a physical handicap. You may be required to submit periodic medical evidence to support the continuation of coverage. Any child identified under a Qualified Medical Child Support Order (QMCSO) will also be covered under this Plan. QMSCOs are discussed in detail on page 9 of the Summary Plan Description.

You must immediately notify the Fund or the Third-Party Administrator when you gain a dependent or when your dependent no longer qualifies for coverage. You are responsible for providing copies of birth certificates, marriage certificates, divorce decrees, or any other documentation the Fund may require. This information must be received by the Fund within 90 days from the date that you or your dependent is eligible for coverage. If the information is not received within this period, benefits for you or your dependent will not be effective until the first of the month in which the information is finally received. Additionally, within 60 days of the event, you must notify the Plan when your dependent is no longer eligible for coverage.

Upon their loss of eligibility for benefits, your dependent children will be able to continue coverage under this HRA Plan by electing COBRA Continuation Coverage and paying a COBRA premium for up to 36-months. If you divorce, your spouse will also have the ability to purchase COBRA Continuation Coverage for up to 36-months.

If you die and still have a balance in your Retiree and Former Employee HRA, your spouse and other Eligible Dependents may continue to apply for reimbursement of Eligible Health Care Expenses until your account is exhausted. If you die and do not have a spouse or any other Eligible Dependents, any balance remaining in your Retiree and Former Employee HRA will be forfeited.

If you return to employment with any employer who is obligated to make contributions to the New York State Teamsters Council Health & Welfare Plan, your participation under the Retiree and Former Employee Health Reimbursement Account Plan will be immediately terminated and your account will be frozen until you again retire or otherwise terminate employment. YOU MUST NOTIFY THE FUND AND THE PLAN'S THIRD-PARTY ADMINISTRATOR IN ADVANCE OF ANY RETURN TO COVERED EMPLOYMENT.