SUMMARY OF MATERIAL MODIFICATIONS
AND
NOTICE TO PARTICIPANTS

NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND
GENERAL ELIGIBLITY & ERISA RIGHTS INFORMATION

(Plan No.: 501; I.D. No.: 15-0551885)

February 18, 2022

Dear Participant:

The following is a notice describing recent changes to the General Eligibility and ERISA Rights booklet of the Summary Plan Description ("SPD") for the New York State Teamsters Council Health & Hospital Fund ("Fund" or "Plan"). These changes were made to comply with recent federal legislation and became effective January 1, 2022. You should keep this notice with your SPD for permanent reference. If you have any questions, please contact the Fund Office at 315-455-9790.

I.

Section 7 ("***Claims and Appeals Procedures***") was amended to add the below language as new subsection "F1," concerning a new "External Review" appeal that may be available to you in certain circumstances related to the No Surprises Act. You should also see the related Summary of Material Modifications for the Fund's Medical Benefit SPD booklet for more information on the No Surprises Act and the types of claims covered.

"**F1. EXTERNAL REVIEW**

You have the right to an 'external review' of certain coverage determinations made by the Plan as described below and in more detail in

the Fund's Medical Benefits SPD booklet section titled 'Protection from Surprise Bills.'

An external review is a request for an independent review of a coverage determination by a third party known as an Independent Review Organization ("IRO"). IROs must be accredited by a nationally recognized accrediting organization and must be assigned to review appeals pursuant to independent, unbiased selection methods. 'Requested service' or 'requested services' refers to the service or services for which you are requesting coverage. You may request an external review only if the requested service is covered by the Plan.

You may have the right to an expedited external review if the timeframe for completion of an expedited internal appeal or a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. Also, you have the right to an expedited external review in connection with final adverse determinations concerning an admission, availability of care, continued stays, or health care services for which you received Emergency Services (as defined in the Fund's Medical Benefits SPD booklet), but have not been discharged from a Facility. The timeframes for determining expedited external reviews are shorter than the timeframes for standard external reviews.

Coverage Determinations Subject to External Review

In general, you may not request an external review unless the Plan has issued a 'final adverse determination' of your request for coverage through the Plan's internal appeal process. However, if you qualify for an expedited external review, you may also file an expedited external review at the same time as filing an expedited internal appeal. You are also eligible for an external review if both parties agree to an external review, even though you have not obtained a final adverse determination.

To be eligible for external review, the final adverse determination issued through the first level of the internal appeal process must be a determination involving consideration of whether the Plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act, which are described in the Fund's Medical Benefits SPD booklet.

Requesting an External Review

If you meet the conditions described above, you or your authorized representative may request an external review by completing and filing the required form with the Plan. The Plan will send the external review

application to you with the notice of final adverse determination. You or your authorized representative will have the opportunity to submit additional information on the requested service; and you may be required to authorize the release of any medical records needed to reach a decision on the external review.

You must file your request for an external review with the claims administrator within four months after receiving a final adverse determination.

Upon receipt of a request for an external review, the Plan must determine if the request meets the requirements for external review and will notify you of its eligibility determination. Upon a determination that the request is eligible for external review, the Plan will assign the appeal to an IRO for review.

Effect of External Review Determination

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Questions

If you do not understand any part of the external review process or if you have questions regarding your right to external review, you may contact the Employee Benefits Security Administration at 1-866-444-3272."

II.

Section 7 ("***Claims and Appeal Procedures***") was also amended by replacing subsection G with the following language to account for this new External Review procedure:

"**G. THE TRUSTEES' DECISION IS FINAL AND BINDING**

The Trustees' (or their designee's) or, if applicable, an external reviewer's, final decision with respect to the review of your appeal will be final and binding upon you. The Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. Any legal action against the Plan may only be started after exhausting all administrative remedies under the Plan and must be started within one year from the date the adverse benefit determination denying your appeal (or, if applicable, the date of the external reviewer's decision) is deposited in the mail to your last known address. Please note that filing a lawsuit without exhausting the Fund's claims and appeals procedures will limit your right to appeal and could cause you to lose benefits to which you would otherwise be entitled."