New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund

SUMMARY PLAN DESCRIPTION

Effective June 1, 2025

Your Funds……Working For You

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IMPORTANT NOTES

1. For purposes of this booklet, the New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund is referred to as the "Fund" or the "Plan." Also, the term "we" refers to the Fund and/or any service administrator under contract or subject to an agreement with the Fund.

2. This Summary Plan Description ("SPD") booklet, together with any attached certificate of insurance issued by HM Life Insurance Company provides information about the eligibility and coverage requirements, benefits provided, claims and appeals rights and procedures, protection of health information and ERISA rights related to your health benefits provided under the Fund. In the event of a conflict between this booklet and the Plan Document, the Plan Document controls.

3. Except as otherwise provided herein, the Fund is administered and operated by the Trustees who have the exclusive right, power, and authority, in their sole and absolute discretion, to administer, apply and interpret the Fund, this booklet, and any other Fund documents and to decide all matters arising in connection with the operation or administration of the Fund and the investment of Fund assets. The Trustees are the sole judge of the standard of proof required in any case and the application and interpretation of this Fund and decisions of the Trustees shall be final and binding on all affected Fund participants (and their beneficiaries) and other affected parties.

4. This booklet describes the Plan as it exists on June 1, 2019. Benefits provided by the Plan are not guaranteed, are not intended or considered to be deferred income, are not vested at any time, are subject to the rules and regulations adopted by the Trustees; and may be modified or discontinued at the Trustees' discretion. The nature and amount of Plan Benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

5. Participants' rights with respect to any claims for benefits that have been denied in whole or part shall be covered by the "Claims and Appeals Procedures" set forth in Section 10 to this booklet.

6. 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.

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

8. It is very important that you enroll in both Part A and Part B of Medicare as soon as you are eligible. Failure to enroll in both parts of Medicare could create a serious financial hardship for you. On the first day of the month that you become eligible for Medicare, the Fund will assume that you are covered by Medicare and you will no longer be covered by this Plan (except as a result of disability).

HEALTH CARE REFORM

You should note that this Plan is a "retiree-only" plan. This means that the coverage offered under this Plan is not required to comply with the protections of the Patient Protection and Affordable Care Act (the "Affordable Care Act"), and many other federal mandates. Among other things, being a retiree-only plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirements that plans provide certain preventive health services with no participant cost sharing and that essential health benefits be provided without any lifetime or annual dollar limits. Further, although retiree-only coverage is considered "minimum essential coverage" for purposes of avoiding the Affordable Care Act's "individual mandate," which requires you to have health coverage or pay a fee, being covered under a retiree-only plan means that you will not be eligible for any premium tax credit for which you may qualify in connection with coverage purchased on the Health Insurance Exchange Marketplace (the "Marketplace"). Thus, you should carefully consider all of your health care options when determining whether to enroll in this Plan. If you would like more information about the Marketplace you should visit www.healthcare.gov.

For information about the Fund's benefits or any information contained in this booklet contact the applicable third-party administrator or the Fund Office.

Section 1.
PLAN ADMINISTRATOR RESPONSIBILITIES

As detailed in Section 12 of this booklet, the Plan Administrator and Named Fiduciary is the Board of Trustees. This means that, except as may otherwise be provided herein, the Fund shall be administered and operated by the Trustees who shall have the exclusive right, power, and authority, in their sole and absolute discretion, to administer, apply and interpret the Fund and any other Fund documents and to decide all matters arising in connection with the operation or administration of the Fund and the investment of Fund assets.

Without limiting the generality of the foregoing, the Trustees shall have the sole and absolute discretionary authority to:

1. take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Fund;

2. formulate, interpret and apply rules, regulations and policies necessary to administer the Fund in accordance with its terms;

3. decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Fund;

4. resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Fund or other Fund documents; and

5. process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the Trustees with respect to any matter arising under the Fund and/or any Fund documents, including this booklet, shall be final and binding on all affected Fund participants (and their beneficiaries) and other affected parties.

Section 2.
PARTICIPANT RESPONSIBILITIES

A. At Enrollment

You are responsible for accurately completing and returning an enrollment form to the Fund Office. Your failure to do so may delay or preclude your eligibility or the payment of claims.

To obtain coverage for you and your dependents (including your legal spouse and eligible children as defined in Section 3 below), you are responsible for providing the following documents at enrollment:

1. A certified copy of your birth certificate;

2. A certified copy of your marriage certificate, if you are married and wish to enroll your legal spouse, and a certified copy of your spouse's birth certificate;

3. A certified copy of the birth certificate or adoption agreement for each of your eligible dependent children who you wish to enroll;

4. A certified copy of any of the following if such documents exist: your spouse's divorce decree from a prior marriage, separation request or family court order stating custody and parent insurance responsibility, if you wish to enroll a stepchild - as an eligible dependent;

5. A certificate of attendance for each eligible child age 19 to 25 attending school, college or other institution of higher education as a full-time student, if you wish to enroll your child who is a full-time student for purposes of the Plan.

6. Completed application form showing that a child is permanently and totally disabled, if you wish to enroll your child who is permanently and totally disabled as described in Section 3, below.

B. Change in Status

You must immediately notify the Fund Office so as to avoid a delay or lapse in eligibility when:

1. You divorce;

2. You have a child, adopt a child, obtain legal custody or wish to cover a stepchild;

3. Your child who is receiving coverage under the Plan (other than as a result of such child's total and permanent disability) attains age 25; or

4. You change your name, mailing address or telephone number. Your local union office or the Fund Office has the necessary enrollment forms or forms to change your address.

You have an obligation to promptly notify the Fund Office in writing following a divorce or legal separation. Unless COBRA is elected, the spouse and children of the spouse (stepchildren of the participant) become ineligible for benefits upon the divorce or legal separation and coverage will terminate. If notice of the divorce or legal separation is not provided to the Fund Office, and as a result, benefits are paid to an ineligible dependent, the Trustees may decide to recover those benefits by treating such benefits as an advance to you, and deducting such amounts from benefits which become due to you until the entire amount of the benefits erroneously paid is recovered. Also, if notice of divorce or legal separation is not provided to the Fund Office within 60-days of the date of divorce or legal separation, your spouse and children of your spouse will lose the right to elect COBRA Continuation Coverage.

Section 3.
ELIGIBILITY AND COVERAGE FOR FUND BENEFITS

A. Initial Eligibility and Coverage

To be eligible to participate in the Fund, you must be active in the New York State Teamsters Council Health & Hospital Fund at the time of retirement, retired and collecting a pension from the New York State Teamsters Conference Pension and Retirement Fund and meet either of the following two (2) requirements:

1. Be at least age 50 with 25 or more years of service in a collectively bargained unit position with UPS; or

2. Be under age 50 with 30 or more years of service in a collectively bargained unit position with UPS.

Service in a collectively bargained unit position shall include all years of service with UPS prior to holding a position in the collectively bargained unit.

You, as the retired employee, are covered if you meet the current eligibility requirements set forth above. The following dependents who meet the Fund's eligibility requirements are also covered:

1. Your legal spouse. Your legal spouse, as defined by the IRS, is eligible for coverage only if he or she was your spouse on the date of your retirement from UPS. A certified copy of your marriage certificate and your spouse's birth certificate must be provided to the Fund Office at the time of your spouse's enrollment.

   However, your spouse **will not be an eligible dependent** if your spouse is employed and your spouse's employer offers your spouse coverage under that employer's group health plan if: (a) your spouse is provided family coverage through your spouse's employer at no cost, or (b) your spouse is provided single coverage through your spouse's employer at a cost of 5% or less of your spouse's wages.

   This means that your spouse cannot "opt out" of coverage provided by his or her employer, or decline coverage available through his or her employer due to a buyout or monetary payment not to enroll for coverage through his or her employer in the circumstances described above and still be eligible for coverage through the Fund. The Fund Office provides a form to be completed by your spouse's employer to verify the cost and coverage available.

   Should your spouse not follow the Fund rules and "opt out" of his or her employer's benefit plan, your spouse will not be covered as an eligible dependent under the Plan when this occurs, regardless of the reason.

If your husband or wife impermissibly "opts out" of family coverage where family coverage is provided at no cost, and the standard Coordination of Benefits rules would cause your spouse's plan, if elected, to be the primary payer of benefits for your dependent children, such dependent children will not be covered as eligible dependents under this Plan. Refer to the Coordination of Benefits Rules in Section 9 for primary coverage information.

2. Eligible Children. This Plan covers your unmarried eligible children to the end of the calendar year following the attainment of age nineteen **(19)**; your unmarried eligible children, to the end of the calendar year following the attainment of age twenty-five **(25)**, that are full-time students and you are primarily responsible for their support; and your unmarried eligible children that are permanently and totally disabled; so long as the unmarried eligible child lives with you more than six months of the calendar year and you are primarily responsible for their support.

Eligible children include: your biological children; adopted children (including children placed with you for adoption) pursuant to a binding agreement or court order; children named in a Qualified Medical Child Support Order which meets the requirements of ERISA as described below.

If your child does not live with you more than six months of the year, and you are divorced or separated pursuant to a judicial order of legal separation from your child's other parent, your child may be eligible for benefits if you are primarily responsible for their support pursuant to the divorce decree or judicial order of legal separation.

In addition, children of your husband or wife who reside in your household (i.e. stepchildren) may also be eligible provided you are primarily responsible for their support and there is no divorce decree establishing the natural parent, other than your husband or wife, as being responsible for providing benefits.

The term "full-time student(s)" means the child is attending courses full-time (as determined by the institution) in a graduate or undergraduate college or university (other than a U.S. Military academy) offering a two **(2)** or four **(4)** year program leading to a degree, such as associate, bachelor, or post graduate, or attending an accredited trade or professional school as the child's full time occupation which provides a degree or certificate of completion with a minimum course of study of twelve **(12)** consecutive months.

A certificate of attendance must be submitted to the Fund Office at enrollment and during each Annual Enrollment period.

Dependent status will end at the end of the calendar year following graduation or withdrawal from school (unless due to disability), whichever occurs first. The Fund reserves the right to determine whether a specific institution satisfies the provisions with respect to status as an accepted college, university, trade or technical school.

The time that a full-time student spends away from home for full-time attendance is counted as time lived with you.

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** turning age nineteen **(19)**; or age twenty-five **(25)** if a full-time student; or was otherwise eligible as a dependent under this program.

The term "primarily responsible for their support" means that you can claim that child on your most recent income tax return, and provide proof to the Fund that you provide more than 50% of their financial support. The Fund may require other proof, in addition to your tax returns, that you are primarily responsible for supporting your child.

Important: Certified birth certificate, 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.

The Omnibus Budget Reconciliation Act of 1993 requires health plan 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) from the Fund Office.

Upon receipt of a Medical Child Support Order, the Plan 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/her dependent child(ren), including any necessary increase in the monthly premium being paid from the Participant's account. The Participant will be required to complete and provide such documentation as may be necessary.

If you have any questions regarding the eligibility requirements that apply to you and your dependents, please contact the Fund Office.

Coverage starts on the day the Fund determines you or your dependents have met the eligibility requirements.

Please Note:

You must immediately notify the Fund Office when you gain a dependent or when your dependent no longer qualifies for coverage. You are responsible for providing the Fund Office 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.

B. Monthly Retiree Contribution Rates

To obtain coverage under the Fund, you will be required to pay monthly contributions as follows:

Date:	Single Coverage Cost	Family Coverage Cost
01/01/2024	$200	$400

Your monthly contributions to the Fund must be automatically deducted from the pension benefits payment you receive from the New York State Teamsters Conference Pension and Retirement Fund, when available.

C. Termination of Eligibility and Coverage for Fund Benefits

Eligibility for Fund Benefits will cease on the **earliest** of the following dates:

1. For you, the retiree, coverage ends: (1) when the Plan ends; (2) upon your death; (3) after 15 years (180 months) of coverage or your attainment of age 65, whichever comes first; or (4) you become eligible for Medicare (except as a result of disability, see below).

2. For your dependent spouse coverage ends: (1) when the Plan ends; (2) upon the death of your spouse; (3) after 15 years (180 months) of coverage; (4) upon divorce or legal separation; or (5) when your spouse becomes eligible for Medicare (except as a result of disability, see below).

3. For your dependent children coverage ends: (1) when the Plan ends; (2) after 15 years (180 months) of coverage; (3) the last day of the calendar year in which the eligible dependent child becomes age 19, or 25 if a full-time student; (4) when the child gets married.

4. In the event you fail to pay the required retiree contributions to the Plan.

5. In the event you return to work with UPS, or any contributing employer to the New York State Teamsters Council Health & Hospital Fund and become eligible for active coverage, regardless of the number of hours that you work, the coverage

under this Plan for you and your dependents will end and the 15 years (180 months) of coverage period will be tolled until you are again covered under this Plan.

D. Disability in Retirement

For a disabled individual entitled to Medicare as a result of a disability, the Plan will continue to provide coverage, supplemental to Medicare (in other words, Medicare is primary), until the individual reaches his or her normal coverage end date. You must notify the Fund immediately after becoming Medicare eligible as a result of a disability.

E. Annual Enrollment Process

Annual enrollment happens every year during the fall. You can choose to keep coverage or waive coverage each year during the annual enrollment period. If you choose to waive coverage, you must notify the Fund Office in writing that you're waiving coverage under the Plan because you have other coverage available. Before you are able to later reinstate coverage in the Plan, you must provide the following:

1. Proof of other coverage within 60 days of losing other coverage, or

2. Copy of HIPAA Certificate from other plan (through December 31, 2014), or

3. Confirmation of Coverage or Coverage Termination notice from other plan, or

4. Letter on company letterhead documenting termination of other coverage.

Full-Time Students: If your dependent child is a full-time student age 19 or older, you must certify full-time student status each year during annual enrollment to maintain the child's coverage. If you do not certify student status, your child's coverage will end on December 31 of the current Plan year. If your child's coverage ends as a result of your failure to certify his or her student status, coverage can be reinstated effective the date your child returns to school full-time (not retroactively to January 1). In this situation, you must call the Fund within 60 days of the return-to-school date in order to add your dependent to your coverage.

Important: You or your dependents must notify the Fund Office of any events that affect eligibility for benefits. Failure to do so could delay or prevent your eligibility or the payment of claims.

F. Deferred Enrollment

Effective May 30, 2019, if you satisfy the service requirements of Section 3(A) but do not commence New York State Teamsters Conference Pension and Retirement Fund pension benefits at the time you lose "active" health coverage, you may defer initial enrollment in this Plan subject to the following conditions:

1. You must not be employed by UPS in a non-collectively bargained unit position.

2. You must provide the Fund with proof satisfactory to the Trustees that you maintained continuous qualifying health coverage during your "Deferral Period." Your other health coverage, to qualify, must be at least "minimum value" coverage as that term is defined in the Patient Protection & Affordable Care Act.

3. Your "Deferral Period" is the time between the end of your active participation in the New York State Teamsters Council Health & Hospital Fund through the date of enrollment in this Plan.

4. You must be retired and collecting a pension from the New York State Teamsters Conference Pension & Retirement Fund as of the date of your enrollment.

5. You must meet all other applicable eligibility conditions under this Plan.

6. Upon enrollment, in addition to the monthly retiree contribution, you must pay the "Deferral Fee." The Deferral Fee is equal to the sum total of monthly retiree contributions you would have paid to this Plan if you did not defer coverage. For purposes of calculating the Deferral Fee, the contribution amount is based on the type of coverage [Single or Family] you elect at enrollment.

   The Deferral Fee is billed on a monthly basis by dividing the total Fee by the number of months you deferred coverage ("monthly charge") and applying that monthly charge going forward for the same number of months eligibility was deferred.

   For example, if your Deferral Period is 12 months and the contributions due during that time would have equaled $1,800, then for your first 12 months of retiree coverage under this Plan you will be charged $150 per month ($1,800 ÷ 12) in addition to the retiree contribution for that month.

   The Deferral Fee monthly charge is automatically deducted from your pension benefits payment. In the event you die prior to satisfaction of the Deferral Fee, any eligible dependents that continue coverage will be responsible for the remainder of the Fee as well as the applicable premium.

7. Your Deferral Period will count against this Plan's 15-year (180 months) coverage limit.

Section 4.
MAJOR MEDICAL BENEFITS

The Medical Benefits ("Medical Benefits") are self-funded by the New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund ("Fund") and administered by Excellus BlueCross BlueShield, Central New York Region:

Excellus BlueCross BlueShield,
Central New York Region ("Excellus" or "EBCBS")
333 Butternut Drive
Syracuse, New York 13214-1803
Telephone: 1-877-650-5840
Website: www.excellusbcbs.com

A. Preferred Provider Network

Medical Benefits are provided through a Preferred Provider Organization ("PPO") product administered by Excellus BlueCross BlueShield ("EBCBS"). Hospitals and other Professional Providers who participate in the PPO are referred to as "In-Network." Hospitals and other Professional Providers who do not participate are referred to as "Out-of-Network." You are free to choose your own hospital and your own doctor. There are no restrictions as long as you use a licensed hospital and a licensed physician. However, if you use an Out-of-Network Provider that does not participate in the PPO Network, you will likely incur greater out-of-pocket costs than if you had used an In-Network Provider.

An In-Network Provider cannot "balance bill" you for any amounts greater than the amount EBCBS has negotiated with the In-Network Provider. The Allowable Expense for In-Network Providers is the amount EBCBS has negotiated with the In-Network Provider or the In-Network Provider's charge, whichever is less.

Unless otherwise specifically provided herein, the "Allowable Expense" for Out-of-Network Providers will be determined by the Plan based on the lowest of (1) the Out-of-Network Provider's charge, (2) the amount approved by the local Blue Cross Blue Shield Plan with whom the Out-of-Network Provider has an agreement, or (3) 100% of the amount EBCBS makes to participating providers for the type of care you receive, based on a regional fee schedule. **The Out-of-Network Provider's actual charge may exceed the Allowable Expense. For anything other than Surprise Bills, you must pay the difference between the Allowable Expense and the Out-of-Network Provider's charge. See the definition of "Allowable Expense" and the section titled "Protection from Surprise Bills" for more information.**"

B. Covered Benefits

The New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund provides the following Medical Benefits:

All amounts payable shown are for covered Medical Services after meeting the Annual Deductible, and are subject to Reasonable and Customary Limitations as described below.

MEDICAL BENEFITS	BLUE CROSS/BLUE SHIELD	
Physician Charges - Non-Preventive Care	**In-Network**	**Out-of-Network**
Medical Office Visit	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum is met
Inpatient Surgery	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum is met
Outpatient Surgery	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum is met
Hospital Facility Charges	**In-Network**	**Out-of-Network**
Inpatient Services	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum is met ($250 Co-Pay)
Outpatient Services	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum is met
Emergency Room	80% benefit, then 100% after Out of Pocket Maximum is met ($100.00 Co-Pay if Non-Emergency Diagnosis)	80% benefit, then 100% after Out of Pocket Maximum is met ($100.00 Co-Pay if Non-Emergency Diagnosis)
Preventive Care Benefits	**In-Network**	**Out-of-Network**
Routine physicals	80% benefit, then 100% after Out of Pocket Maximum is met	Not Covered
Routine OB/GYN Care	80% benefit, then 100% after Out of Pocket Maximum is met	Not Covered
Routine mammograms	80% benefit, then 100% after Out of Pocket Maximum is met	Not Covered
Well-childcare	80% benefit, then 100% after Out of Pocket Maximum is met	Not Covered
Behavioral Health Benefits	**In-Network**	**Out-of-Network**
Mental Health & Substance Abuse - Inpatient	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum is met
Mental Health & Substance Abuse - Outpatient	80% benefit, then 100% after Out of Pocket Maximum is met (Limit 30 visits for mental health and 30 visits for substance abuse per calendar year. In & Out of Network combined)	70% benefit, then 100% after Out of Pocket Maximum is met (Limit 30 visits for mental health and 30 visits for substance abuse per calendar year. In & Out of Network combined)
Other Medical Benefits	**In-Network**	**Out-of-Network**
Diagnostic x-ray and lab	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum is met

Hospice care - outpatient	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum is met
Skilled nursing facility	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum; limit 60 days
Chiropractic: $1,000 maximum per person per year	80% benefit, maximum $40/visit	70% benefit, maximum $40/visit
Home care	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum; limit 120 visits
Durable Medical Equipment	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum is met
Physical Rehabilitation	80% benefit, then 100% after Out of Pocket Maximum is met	70% benefit, then 100% after Out of Pocket Maximum; limit 60 days
Outpatient Private Duty Nursing - medically necessary provided by RN or LPN	80% benefit, then 100% after Out of Pocket Maximum is met (Limit 560 hours per calendar year combined In & Out of Network)	70% benefit, then 100% after Out of Pocket Maximum is met (Limit 560 hours per calendar year combined In & Out of Network))
Hearing Aids	80% benefit, then 100% after Out of Pocket Maximum is met (Adult Lifetime limit - 2 hearing aids) (Children to age 19 – limit 2 hearing aids every 3 years)	70% benefit, then 100% after Out of Pocket Maximum is met (Adult Lifetime limit - 2 hearing aids) (Children to age 19 – limit 2 hearing aids every 3 years)

C. Annual Deductible and Limitations

All amounts payable shown above are for covered Medical Services after meeting the Annual Deductible, and are subject to Reasonable and Customary Limitations as follows:

Basic Medical Provisions		
	In Network	**Out of Network**
Annual Deductible	$200 Single / $400 Family	$200 Single / $400 Family
Annual Out of Pocket Maximum (deductible and coinsurance apply to maximum)	$1,000 per person	$1,000 per person
Lifetime Plan Maximum (includes Prescription)	**$500,000 per person**	

Please Note: Your health coverage, offered by the New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund**, is not obligated to comply with certain Affordable Care Act provisions described herein.**

D. Definitions

For purposes of this SPD booklet, capitalized words or phrases shall have the following meanings unless otherwise provided herein:

1. **Allowable Expense.** "Allowable Expense" means the maximum amount the Plan will pay to a Facility, Professional Provider or Provider of Additional Health Services for the services or supplies covered under the Plan before any applicable Deductible, Copayment and Coinsurance amounts are subtracted.

   The "Allowable Expense" for In-Network Providers will be the amount EBCBS has negotiated with the In-Network Provider or the In-Network Provider's charge, whichever is less. However, when the In-Network Provider's charge is less than the amount EBCBS has negotiated with the In-Network Provider, your Coinsurance, Copayment or Deductible amount will be based on the In-Network Provider's charge.

   Unless otherwise specifically provided herein, the "Allowable Expense" for Out-of-Network Providers will be determined by the Plan based on the lowest of (1) the Out-of-Network Provider's charge, (2) the amount approved by the local Blue Cross Blue Shield Plan with whom the Out-of-Network Provider has an agreement, or (3) 100% of the payment amount EBCBS makes to participating providers for the type of care you receive, based on a regional fee schedule. **The Out-of-Network Provider's actual charge may exceed the Allowable Expense. For anything other than Surprise Bills, you must pay the difference between the Allowable Expense and the Out-of- Network Provider's charge.**

Ground Ambulance. The "Allowable Expense" for an Out-of-Network Provider for ground ambulance, other than ground ambulance that may be considered as part of a Surprise Bill, will be the Out-of-Network Provider's charge.

Surprise Bills. The "Allowable Expense" for Surprise Bills for an Out-of-Network Provider will be the lesser of the Out-of-Network Provider's charge or the "Qualifying Payment Amount." See the section titled "Protection from Surprise Bills" below for what constitutes a Surprise Bill and how the Qualifying Payment Amount is determined.

Physician-Administered Pharmaceuticals. For physician-administered pharmaceuticals, the Plan uses gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale prices for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or EBCBS based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

2. **Biologically-Based Mental Illness.** A mental, nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Biologically-based mental illnesses are defined as the following:

   a. Schizophrenia/psychotic disorders;

   b. Major depression;

   c. Bipolar disorder

   d. Delusional disorders;

   e. Panic disorder;

   f. Obsessive compulsive disorder;

   g. Bulimia; and

   h. Anorexia.

3. **Calendar Year.** The 12-month period beginning on January 1 and ending on December 31. However, if you were not covered under this Plan for the entire period, Calendar Year means the period from the date you become covered until December 31.

4. **Coinsurance.** A charge, expressed as a percentage of the Allowable Expense, that you must pay for certain services covered under this Plan. You are responsible for payment of any Coinsurance directly to the provider.

5. **Copayment.** A charge, expressed as a fixed dollar amount that you must pay for certain health services covered under this Plan. You are responsible for the payment of any Coinsurance directly to the provider.

6. **Deductible.** A charge, expressed as a fixed dollar amount that you must pay once each Year before we will pay anything for In-Network and Out-of-Network Benefits covered under this Plan during that Year.

7. **Emergency Condition.** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in the Emergency Medical Treatment and Active Labor Act ("EMTALA"), including: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

7. A **Emergency Services.** With respect to an Emergency Condition, a medical screening examination (as required under EMTALA or as would be required under EMTALA if it applied to an Independent Freestanding Emergency Department) which is within the capability of the emergency department of a Hospital (or Independent Freestanding Emergency Department), including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital (or Independent Freestanding Emergency Department) and such further medical examination and treatment as are required to stabilize the patient, regardless of the department of the Hospital in which further examination or treatment is furnished.

"Emergency Services" also include certain post-stabilization services, unless the following conditions are met:

(1) The attending emergency physician or treating provider has determined that you are able to travel using nonmedical transportation or non-emergency medical transportation to an available In-Network Provider or Facility located within a reasonable travel distance, taking into account your medical condition and any other relevant factor;

(2) If the Provider is an Out-of-Network Provider, (a) the Provider gives you notice that the services rendered will be performed by an Out-of-Network Provider, and you consent to waive your rights under the surprise bill requirements, and (b) you or your authorized representative are in a condition to provide informed, voluntary consent; and

(3) The Provider satisfies any additional applicable laws and requirements including, without limitation, those provided in guidance issued by the Department of Health and Human Services

8. **Facility.** A Hospital; ambulatory surgery facility; birthing center; dialysis center; rehabilitation facility; Skilled Nursing Facility, hospice; home health agency or home care services agency; an institutional provider of mental health or chemical dependence and abuse treatment; or other provider. If you receive treatment for chemical dependence or abuse outside of New York State, the Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") to provide a chemical abuse treatment program.

9. **Gene Therapy.** Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. The Fund does not cover any charges related to gene therapy, regardless of whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational. Examples of gene therapy include, but are not limited to, Zolgensma, Luxturna, and Chimeric Antigen T-Cell (CAR-T) Therapies such as Kymriah and Yescarta.

9A**.** **Independent Freestanding Emergency Department**. A health care facility that provides Emergency Services and is geographically separate and distinct and licensed separately from a Hospital under applicable state law.

10. **Hospital.** Any short-term acute general hospital facility that is accredited as a hospital and is certified under Medicare. A Hospital is a licensed institution primarily engaged in providing:

a. Inpatient diagnostic and therapeutic services for surgical and medical diagnosis;

b. Treatment and care of injured and sick persons by or under the supervision of physicians; and

c. Twenty-four (24) hour nursing service by or under the supervision of registered nurses.

None of the following are considered Hospitals:

a. Hospitals for treatment of mental illness. If you are a patient in a separate division or unit of a Hospital dedicated to the treatment of mental illness where the average length of stay is more than 30 days, that separate division or unit is not considered a Hospital;

b. Places primarily for nursing care;

c. Skilled Nursing Facilities;

d. Convalescent homes or similar institutions;

e. Institutions primarily for: custodial care; rest; or as domiciles;

f. Health resorts; spas; or sanitariums;

g. Infirmaries at schools; colleges; or camps;

h. Places primarily for the treatment of chemical dependence and abuse; hospice care; or rehabilitation;

i. Free standing ambulatory surgical centers.

11. **In-Network Benefits.** In-Network Benefits are the highest level of coverage available. In-Network Benefits apply when your care is provided by In-Network Providers.

12. **In-Network Provider.** A Facility, Professional Provider or Provider of Additional Health Services who has a contract with EBCBS or another Blue Cross and/or Blue Shield plan to provide services to you at a discounted rate. In-Network Providers have agreed to accept the discounted rate as payment in full for services covered under the Plan. A list of In-Network Providers is included in a provider directory and is available at www.excellusbcbs.com or upon request by calling the customer service number located on your identification card. The list may be revised from time to time. The In-Network Provider directory will give you the following information about In-Network Providers:

(1) Name, address and telephone number;

(2) Specialty;

(3) Board certification (if applicable);

(4) Languages spoken; and

(5) Whether the In-Network Provider is accepting new patients.

You are only responsible for any In-Network Provider Copayment, Deductible or Coinsurance that would apply to the covered services, and you will not be responsible for paying for any Out-of-Network charges that exceed your In-Network Provider Copayment, Deductible or Coinsurance if you receive covered services from a provider who is not an In-Network Provider because you reasonably relied on incorrect information the Plan or EBCBS provided about whether the provider was an In-Network Provider in the following situations:

(1) The provider is listed as an In-Network Provider in the online provider directory;

(2) The paper provider directory listing the provider as an In-Network Provider is incorrect as of the date of publication;

(3) You were given written notice that the provider is an In-Network Provider in response to your telephone request for network status information about the provider; or

(4) You are not provided with written notice within one business day of your telephone request for network status information.

13. **Medical Necessity.** See Section E.

14. **Member.** Any Participant or eligible dependent who meets all applicable eligibility requirements and who is covered under this Plan.

15. **Mental Illness.** A mental, nervous or emotional condition that we determine has treatable behavioral manifestations and that we also determine:

a. Is a clinically significant alteration in thinking, mood or behavior, or a combination thereof; and

b. Substantially or materially impairs your ability to function in one or more major life activities; and

c. Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

16. **Out-of-Network Benefits.** The Out of-Network Benefits portion of this Plan covers health care services described in this Plan when you choose to receive the covered services from Out-of-Network Provider. When you receive Out-of-Network Benefits, you will incur out-of-pocket expenses. You will be responsible for meeting an annual Deductible and for paying a Coinsurance amount as well as paying any difference between the Allowable Expense and the provider's charge.

17. **Out-of-Network Provider.** A Facility, Professional Provider or Provider of Additional Health Services that does not have a provider agreement with us or any other Blue Cross and/or Blue Shield Plan to provide health services to Members.

18. **Plan.** The benefits and provisions described in this document.

19. **Plan Administrator.** The Plan Administrator is the Board of Trustees of the Fund, who are fiduciaries of the Plan. The Board of Trustees has all discretionary authority to interpret the provisions and control the operation and administration of the Plan.

20. **Precertification.** The process of reviewing the necessity, appropriateness, location, duration and/or cost efficiency of a health care service before it is rendered.

21. **Preferred Provider Organization (PPO).** A network of Facilities, Professional Providers and Providers of Additional Health Services that have provider agreements with a Blue Cross and/or Blue Shield Plan to provide health services to Members.

22. **Professional Provider.** A certified and licensed physician; osteopath; dentist; optometrist; chiropractor; registered psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; licensed midwife; speech-language pathologist; audiologist; or any other licensed health care provider.

23. **Provider of Additional Health Services.** A provider of services or supplies covered under this Plan (such as diabetic equipment and supplies, prosthetic devices or durable medical equipment) that is not a Facility or Professional Provider, and that is; licensed or certified according to applicable state law or regulation; approved by the applicable accreditation body, if any; and/or recognized by us for payment under this Plan.

24. **Skilled Care.** A service that we determine is furnished by or under the direct supervision of licensed medical personnel to assure the safety of the patient and achieve the medically desired results as defined by medical guidelines. A service is not considered a skilled service merely because it is performed or supervised by licensed medical personnel. However, it is a service that cannot be safely and adequately self-administered or performed by the average non-medical person without the supervision of such personnel.

25. **Skilled Nursing Facility.** A facility accredited as a Skilled Nursing Facility or qualified as a Skilled Nursing Facility under Medicare.

26. **Year.** The 12-month period on which the Deductible and Coinsurance and any annual limits under this Plan are based. Unless otherwise indicated, the 12-month period is the Calendar Year as defined above.

E. Medical Necessity and Prior Authorization

1. **Care Must Be Medically Necessary.** The Plan will provide coverage for the covered benefits described in the Booklet as long as the hospitalization, care, service, technology, test, treatment, drug or supply (collectively, "Service") is Medically Necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the Service does not make it Medically Necessary or mean that the Fund must provide coverage for it.

   Services will be deemed Medically Necessary only if:

   a. They are clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease;

b. They are required for the direct care and treatment or management of that condition;

c. If not provided, your condition would be adversely affected;

d. They are provided in accordance with generally-accepted standards of medical practice;

e. They are not primarily for the convenience of you, your family, the Professional Provider or another provider;

f. They are not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease; and

g. When you are an inpatient, your medical symptoms or conditions are such that diagnosis and treatment cannot safely be provided to you in any other setting (e.g., outpatient, physician's office or at home).

2. **Service Must Be Approved Standard Treatment.** Expect as otherwise required by law, no Service rendered to you will be considered Medically Necessary unless it is determined the Service is consistent with the diagnosis and treatment of your medical condition; generally accepted by the medical profession as approved standard treatment for your medical condition; and considered therapeutic or rehabilitative.

3. **Services Subject to Prior Approval.** Prior approval is required before you receive certain services covered under this Plan. The services subject to prior approval are:

   a. all services relating to organ and tissue transplants;

   b. all In-Network benefits and Out-of-Network Benefits for inpatient admissions, excluding maternity admissions;

   c. all Skilled Nursing Facility admissions;

   d. all Home Care services.

4. **Prior Approval Procedure.** Members who seek coverage for the services listed in **Services Subject to Prior Approval** above must call Excellus at the number indicated on their identification card to have the care pre-approved. We request that you call at least seven days prior to a planned inpatient admission.

   If you are hospitalized in cases of an Emergency Condition involving any of these services, you should call Excellus within 24 hours after your admission or as soon thereafter as reasonably possible. However, you must call the Excellus as soon as it is reasonably possible in order for any follow-up care to be covered. The availability of an organ for transplantation resulting in the necessity for an

immediate admission for implantation shall be considered an Emergency Condition for purposes of this paragraph.

After receiving a request for approval, Excellus will review the reasons for your planned treatment and determine if benefits are available. Excellus will notify you and your Professional Provider of its decision by telephone and in writing within three business days of receipt of all necessary information. If your treatment involves continued or extended health care services, or additional services for a course of continued treatment, Excellus will notify you and your Professional Provider within one business day of receipt of all necessary information.

5. **Failure to Seek Approval.** If you fail to seek prior approval for Out-of-Network benefits subject to this Section, you will be required to pay a $250 Copayment penalty per occurrence. The Plan will pay the amount specified in Section 4(B) only if it is determined that the care was Medically Necessary even though you did not seek prior approval. If it determined, in sole judgment of the Plan Administrator, that the services were not Medically Necessary, you will be responsible for paying the entire charge for the service.

6. **Courtesy Authorization**. While not required, prior to receiving the services, you may ask your Professional Provider to contact Excellus to confirm that a certain procedure or service will be covered by the Plan. For example, prior to undergoing a PET scan, your Professional Provider may contact Excellus to determine whether it is covered as Medically Necessary.

F. Cost Sharing Expenses

1. **Copayments.** The copayments you must pay for covered services when you are entitled to In-Network Benefits are set forth in the Section 4(B).

2. **Deductible.** There are separate deductibles for In-Network and Out-of-Network services. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. Once the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that year. The annual individual and family deductible amounts are shown in the Section 4(C).

3. **Coinsurance.** Except where stated otherwise, after you have satisfied the annual Deductible described above, you will be responsible for a percentage of the Allowable Expense. The Coinsurance amounts you must pay are set forth in Section 4(B).

4. **Additional Payments For Out-of-Network Benefits.** When you receive covered services from an Out-of-Network Provider, in addition to the Coinsurance and the annual Deductible described above, you must also pay the amount, if any, by which the provider's actual charge exceeds the Allowable Expense. This means that the

total of our coverage and your Deductible and Coinsurance may be less than the provider's actual charge.

5. **Out of Pocket Maximum.** There are separate Out of Pocket Maximums for In-Network and Out-of-Network services. An out-of-pocket maximum is the maximum amount of coinsurance payable for covered expenses each covered individual must pay during a year, including the Deductible and Copayments. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of additional covered expenses for the remainder of that year. The annual Out of Pocket Maximums are shown in Section 4(C).

6. **Annual Limit**: The Annual Limit is the total amount that the Plan will pay for covered expenses, inclusive of prescription drug benefits, during the Plan Year. The Annual limits are set forth in Section 4(B).

7. **Lifetime Maximum Benefit.** The Lifetime Maximum Benefit is the total amount that the Plan will pay for covered expenses, inclusive of prescription drug benefits, during the individual's lifetime. The Lifetime Maximum Benefit is shown in Section 4(C).

G. Inpatient Care

1. **In A Facility.** If you are a registered bed patient in a Facility, the Plan will provide coverage for most of the services provided by the Facility, subject to the conditions and limitations listed in **Conditions for Inpatient Care** below. The services must be given to you by an employee of the Facility; the Facility must bill for the services; and the Facility must retain the money collected for the services.

2. **Services Not Covered.** We will not provide coverage for:

   a. Additional charges for special duty nurses;

   b. Private room, unless we determine that it is Medically Necessary for you to occupy a private room or the Facility has no semi-private rooms. If you occupy a private room in a Facility, and we determine that a private room is not Medically Necessary or that the Facility does have semi-private rooms, our coverage will be based upon the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room;

   c. Blood, except we will provide coverage for blood required for the treatment of hemophilia. However, we will provide coverage for blood and blood products when participation in a voluntary blood replacement program is not available to you;

   d. Non-medical items, such as telephone or television rental;

e. Medications, supplies, and equipment which you take home from the Facility; or

f. Custodial care.

3. **Conditions For Inpatient Care.** Inpatient Facility care is subject to the following conditions:

a. **Inpatient Hospital Care.** We will provide coverage when you are required to stay in a Hospital for acute medical or surgical care and are not admitted to the hospital for mental health care or for diagnosis and treatment of chemical dependence and/or abuse. We will provide coverage for any day on which it is Medically Necessary for you to receive inpatient care.

b. **Mental Health Care.** We will provide coverage for diagnosis and treatment of Mental Illness in a "hospital" as defined by subdivision ten of section 1.03 of the New York Mental Hygiene Law. The term "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meets standards prescribed pursuant to the regulations of the Commissioner of Mental Health.

We will also provide coverage for care in a licensed partial hospitalization program. A partial hospitalization program is an ambulatory treatment program that provides a medically supervised alternative to inpatient treatment.

The coverage described above includes benefits for Biologically-Based Mental Illness and for Children with Serious Emotional Disturbances.

c. **Inpatient Detoxification.** We will provide coverage for active treatment for detoxification needed because of chemical dependence. This coverage is available only for services rendered in and billed by:

i. Facility in New York State which is certified by the Office of Alcoholism and Substance Abuse Services;

ii. A program we recognize as a chemical dependence and abuse treatment program; or

iii. A Facility in another state that we recognize is approved as an alcoholism or chemical dependence and abuse treatment program and meets the appropriate state licensing. If a government hospital meets these criteria, services rendered there will be covered unless no charge would have been made in the absence of coverage under this Plan.

d. **Skilled Nursing Facility.** We will provide coverage for care in a Skilled Nursing Facility if we determine that hospitalization would otherwise be Medically Necessary for the care of your condition, illness or injury.

e. **Physical Rehabilitation.** We will provide coverage for comprehensive physical medicine and rehabilitation (chemical dependence and abuse programs are excluded) for a condition that in the judgment of your Professional Provider can reasonably be expected to result in significant improvement within a relatively short period of time.

f. **Inpatient Chemical Dependence and Abuse Rehabilitation.** We will provide coverage for the diagnosis and active treatment for rehabilitation of chemical dependence and abuse. We will provide covered services for a 24-hour live-in program of services in a Facility that is a Plan approved provider for the active rehabilitation and treatment of chemical abuse. The program is non-medical and provides rehabilitation and treatment for chemical abuse or dependence in a controlled environment.

4. **Maternity Care**. We will provide coverage for inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, if covered under this Plan, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also provide coverage for any additional days of such care that we determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum coverage period, we will provide coverage of the home care visit furnished by the type of home care agency. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. Our coverage of this home care visit shall not be subject to any Copayment amounts, or any Coinsurance or Deductible amounts.

5. **Mastectomy Care.** Our coverage of inpatient Hospital care includes coverage of an inpatient Hospital stay following a lymph node dissection, lumpectomy, or mastectomy for the treatment of breast cancer. The length of stay will be determined by you and your Professional Provider. We will also provide coverage for prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

6. **Internal Prosthetic Devices.** Our coverage for inpatient Hospital care includes coverage for internal prostheses that are surgically implanted and Medically Necessary for anatomical repair or reconstructive purposes. Internal prosthetic devices are designed to replace all or part of a permanently inoperative, absent or malfunctioning body organ. Examples of internal prosthetic devices include pacemakers, implanted cataract lenses and surgically implanted hardware necessary for joint repair or reconstruction.

7. **Observation Stay.** We will provide coverage for observation services for up to 23 hours observation. Services are: furnished in the outpatient department of a Facility; and are in lieu an inpatient admission. The services include: use of a bed and periodic monitoring by nursing or other licensed staff that is reasonable and necessary to evaluate the patient's condition or determine the need for an inpatient admission.

H. Outpatient Care

We will provide coverage for the same services we would cover if you were an inpatient in connection with the care described below when given to you in the outpatient department of a Facility. As in the case of inpatient care, the service must be given by an employee of the Facility; the Facility must bill for the service; and the Facility must retain the money collected for the service.

1. **Care In Connection With Surgery.** We will only provide coverage if we determine that it was Medically Necessary to use the Facility to perform the surgery.

2. **Pre-Admission Testing.** We will provide coverage for tests ordered by a physician which are given to you as a preliminary to your admission to the Facility as a registered bed patient for surgery if all of the following conditions are met:

   a. They are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;

   b. A reservation has been made for the Facility bed and/or the operating room before the tests are given;

   c. You are physically present at the Facility when these tests are given; and Surgery actually takes place within seven days after the tests are given.

3. **Diagnostic Imaging.** We will provide coverage for diagnostic imaging procedures, including x-rays, ultrasound, computerized axial tomography ("CAT") and positron emission tomography ("PET") scans and magnetic resonance imaging ("MRI") procedures.

4. **Laboratory And Pathology Services.** We will provide coverage for diagnostic and routine laboratory and pathology services.

5. **Radiation Therapy.** We will provide coverage for radiation therapy.

6. **Chemotherapy.** We will provide coverage for chemotherapy.

7. **Dialysis.** We will provide coverage for dialysis treatments of an acute or chronic kidney ailment.

8. **Mental Health Care**. We will provide benefits for diagnosis and treatment of Mental Illnesses as provided in Section 4(B).

   The coverage described above includes benefits for Biologically-Based Mental Illness and for children with serious emotional disturbances.

9. **Chemical Dependency**. We will provide coverage for outpatient visits for the diagnosis and treatment of chemical dependence. Each individual visit must consist of at least one of the following: individual or group chemical dependence counseling; activity therapy; family therapy; and diagnostic evaluations by a Professional Provider to determine the nature and extent of your illness or disability. We will not provide coverage for visits that consist primarily of participation in programs of a social, recreational or companionship nature. Family therapy consists of visits that include members of your family in order for your family to understand the illness of another family member and play a meaningful role in the family member's recovery. Our coverage of a family visit will be the same regardless of the number of family members who attend the family visit. The family therapy visits may only be used by people who are covered under this Plan as provided for in Section 4(B).

10. **Covered Therapies**. We will provide coverage for related rehabilitative physical therapy and physical, occupational and speech therapy when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist and when we determine that your condition is subject to significant clinical improvement through relatively short-term therapy.

11. **Pulmonary Rehabilitation**. We will provide coverage for Medically Necessary patient assessment and formal training and education phases of pulmonary rehabilitation programs. Services must be rendered by an approved pulmonary rehabilitation program provider and recommended by the Member's cardiologist or Professional Provider.

12. **Cardiac Rehabilitation**. We will provide coverage for Medically Necessary cardiac rehabilitation programs. Services must be rendered by an approved cardiac rehabilitation program provider and recommended by the Member's cardiologist or Professional Provider.

13. **Injectable Drug Copayments**. When drugs are administered by injection during the course of an outpatient visit covered under this section, you are responsible for a Copayment for the drug(s). The drug Copayment is in addition to the Copayment, if any, that applies to the outpatient visit.

14. **Telemedicine Program.** Effective January 1, 2019, participants and their eligible dependents enrolled in the Medical Benefits Plan may utilize the Excellus BlueCross BlueShield Telemedicine Program for appropriate covered services. The Program provides on-demand or by appointment doctor visits by telephone or web-based video with participating physicians. As a participant, you will receive

information regarding how to register for the Program and, once registered, how to utilize the Program. You will not be charged for a Telemedicine visit under this Program for covered services so long as you are registered, and the vendor is able to confirm your coverage at the point of service.

I. Home Care

1. **Type of Home Care Provider**. We will provide coverage for home care visits given by a certified home health agency or licensed home care services agency if your Professional Provider determines that the visits are Medically Necessary.

2. If operating outside of New York State, the home health agency or home care services agency must be qualified by Medicare.

3. **Eligibility for Home Care**. We will provide coverage for home care only if all the following conditions are met:

   a. A treatment plan is established and approved in writing by your Professional Provider;

   b. You apply to the home care provider through your Professional Provider with supporting evidence of your need and eligibility for the care; and

   c. The home care is related to an illness or injury for which you were hospitalized or for which you would have been hospitalized or confined in a nursing facility. The care must be Medically Necessary at a skilled or acute level of care.

   You will not be entitled to coverage of any home care after the date we determine that you no longer need such services.

4. **Home Care Services Covered**. Home care will consist of one or more of the following:

   a. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse;

   b. Part-time or intermittent home health aide services, that consist primarily of direct care rendered to you;

   c. Physical, occupational or speech therapy provided by the home health agency or home care services agency; and

   d. Medical supplies, drugs and medications prescribed by your physician, laboratory services, durable medical equipment and infusion therapy, when provided by or on behalf of the home health agency or home care services agency, but only to the extent such items would have been covered under this Plan if you were an inpatient in a Hospital or Skilled Nursing Facility.

For purposes of this paragraph, "part-time or intermittent" means no more than 35 hours per week.

5. **Failure to Comply with Treatment Plan**. If you fail or are unable to comply with the home care treatment plan, we will terminate benefits for that plan of care.

6. **Number of Visits**. We will provide coverage beginning with the first day on which care is provided as outlined in Section 4(B).

J. Hospice Care

1. **Eligibility for Benefits**. In order to receive these benefits, which are non-aggressive services provided to maintain the comfort, quality and dignity of life to the terminally ill patient, you must meet the following conditions:

   a. The attending physician estimates your life expectancy to be six months or less.

   b. Palliative care (pain control and symptom relief), rather than curative care, is considered most appropriate.

2. **Hospice Organizations**. In New York State we will provide coverage only for hospice care provided by a hospice organization that has an operating certificate issued by the New York State Department of Health. If the hospice care is provided outside of New York State, the hospice organization must have an operating certificate issued under criteria similar to those used in New York by a state agency in the state where the hospice care is provided, or it must be approved by Medicare.

3. **Hospice Care Benefits**. We will provide coverage for the following services when provided by a hospice:

   a. Bed patient care provided by the hospice organization either in a designated hospice unit or in a regular hospital bed;

   b. Day care services provided by the hospice organization;

   c. Home care and outpatient services which are provided and billed through the hospice. The services may include at least the following:

      i. Intermittent nursing care by an R.N., L.P.N., or home health aide;

      ii. Physical therapy;

      iii. Speech therapy;

      iv. Occupational therapy;

      v. Respiratory therapy;

vi. Social services;

vii. Nutritional services;

viii. Laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms;

ix. Medical supplies;

x. Drugs and medications that require a prescription by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary. We will not provide coverage when the drug or medication is of an experimental nature;

xi. Durable medical equipment;

xii. Bereavement services provided to your family during illness, and until one year after death; and

xiii. Medical care provided by a physician.

4. **Number of Visits**. We will provide coverage for unlimited days of hospice care, beginning with the first day on which care is provided as provided in Section 4(B). Each day you receive care from or through the hospice counts as a day of hospice care. We will also provide coverage for up to five visits for bereavement counseling services to your family, either before or after your death.

K. Professional Services

We will provide coverage for the services of Professional Providers as described below.

1. **Surgery**. Surgery includes operative procedures for the treatment of disease or injury. It includes any pre- and post-operative care usually rendered in connection with such procedures. Pre-operative care includes pre-operative examinations that result in a decision to operate. Surgery also includes endoscopic procedures and the care of fractures and dislocations of bones.

2. We will also provide coverage for certain surgical services in connection with a mastectomy including all stages of reconstructive surgery on a breast on which a mastectomy has been performed. We will also provide coverage for reconstructive surgical procedures on the other breast to produce a symmetrical appearance. We will also provide coverage for prostheses and treatment of physical complications of a mastectomy, including lymphedemas. Coverage will be provided for all such services rendered in the manner determined appropriate by you and your Professional Provider.

3. **Inpatient Surgery**. We will provide coverage for surgical procedures performed while you are an inpatient in a Hospital or other Facility.

4. **Outpatient Surgery**. We will provide coverage for surgical procedures performed in the outpatient department of a Hospital or other Facility or in a Hospital-based or freestanding ambulatory surgery facility.

5. **Office Surgery**. We will provide coverage for surgical procedures performed in the Professional Provider's office.

6. **Covered Therapies**. We will provide coverage for related rehabilitative physical therapy and physical, occupational and speech therapy when services are rendered by a licensed physical therapist, occupational therapist or speech language pathologist or audiologist and when we determine that your condition is subject to significant clinical improvement through relatively short-term therapy.

7. **Anesthesia Services**. This includes the administration of necessary anesthesia and related procedures in connection with a covered surgical service. The administration and related procedures must be done by a Professional Provider other than the Professional Provider performing the surgery or an assistant. We will not provide coverage for the administration of anesthesia for a procedure not covered by this Plan.

8. **Additional Surgical Opinions**. We will provide coverage for a second opinion, or a third opinion if the first two opinions do not agree, with respect to proposed surgery subject to all the following conditions:

   a. You seek the second or third surgical opinion after your surgeon determines your need for surgery.

   b. The second or third surgical opinion is rendered by a physician:

      i. Who is a board-certified specialist; and

      ii. Who, by reason of his or her specialty, is an appropriate physician to consider the proposed surgical procedure.

   c. The second or third surgical opinion is rendered with respect to a surgical procedure of a non-emergency nature for which benefits would be provided under this Plan if such surgery was performed.

   d. You are examined in person by the physician rendering the second or third surgical opinion.

L. The specialist who renders the opinion does not also perform the surgery

1. **Second Medical Opinions**. We will provide coverage for an office visit in connection with a second medical opinion concerning a positive or negative diagnosis of cancer or a recurrence of cancer. A positive diagnosis of cancer occurs when you are diagnosed by your Professional Provider as having some form of

cancer. A negative diagnosis of cancer occurs when your Professional Provider performs a cancer-screening exam on you and finds that you do not have cancer, based on the exam results. We will also provide coverage for a second medical opinion concerning any recommendation of a course of treatment of cancer. The second medical opinion must be rendered by an appropriate specialist, including but not limited to, a specialist associated with a specialty care center for the treatment of cancer. You will be entitled to In-Network Benefits when your Professional Provider provides a written referral to an Out-of-Network Professional Provider.

2. **Maternity Care.** The Plan will provide coverage for:

   a. **Normal Pregnancy.** Maternity care includes the first visit upon which a positive pregnancy test is determined. It also includes all subsequent prenatal and postpartum care. These benefits include the services of a licensed midwife, under qualified medical direction, affiliated or practicing in conjunction with a licensed Facility. We will also provide coverage for the following for pregnant women:

      i. Asymptomatic Bacteriuria Screening (UTI)

      ii. RH (D) Incompatibility Screening

      iii. Daily folic acid supplements for women capable of becoming pregnant

      iv. Hepatitis B Virus Infection, Screening

      v. Breastfeeding, Primary Care Interventions to Promote

      vi. Iron Deficiency, Anemia, Prevention – Screening

      vii. Sexually Transmitted Infections Counseling

      viii. STD Testing based on risk (other than Chlamydia, HIV)

      ix. Syphilis Infection Screening

   b. **Complications of Pregnancy and Termination**. We will provide coverage for complications of pregnancy and for terminations of pregnancy.

   c. **Anesthesia**. We will provide coverage for delivery anesthesia.

3. **Inpatient Medical Services**. We will provide coverage for medical visits by a Professional Provider on any day of inpatient care covered under this Plan. We will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers.

The Professional Provider's services must be documented in the Facility records. We will cover only one visit per day per Professional Provider. However, services rendered by up to two Professional Providers on a single day will be covered if the two Professional Providers have different specialties and are treating separate conditions.

4. **Preventive Care Benefits for Adults**. We will provide coverage for the following preventive care services for adults whether performed in a Facility or in a Professional Provider's office:

   a. Abdominal Aortic Aneurysm Screening in men aged 65 – 75

   b. Adult Immunizations

   c. Alcohol Misuse Screening & Behavioral Counseling Interventions

   d. Bone Density (Osteoporosis) for women

   e. Breast and Ovarian Cancer Susceptibility & Genetic Risk Assessment

   f. and BRCA Mutation Testing

   g. Breast Cancer Screening

   h. Cervical Cancer Screening

   i. Chlamydia Screening for women and pregnant women

   j. Colorectal Cancer Screening – Colonoscopy, Signomoidoscopy, Laboratory & Pathology

   k. Depression Screening

   l. Diabetes screening

   m. Diet, Behavioral Counseling in Primary Care to promote a healthy diet – Dietician & Physician

   n. Gonorrhea & Screening for women and pregnant women

   o. High Blood Pressure screening

   p. HIV Screening

   q. Lipid Screening

   r. Obesity Screening

s. Sexually Transmitted Infections, counseling for at risk populations

t. Syphilis Infection Screening in at risk populations

u. Tobacco Use and Tobacco-Caused Disease, Counseling

5. **Medical Care in a Professional Provider's Office**. Unless otherwise provided below, the following services are covered in a Professional Provider's office:

a. **Routine Physical Examinations**. We will provide coverage for periodic adult routine physical examinations in accordance with a schedule based on national coverage determinations, but not to exceed one examination per Member, per Year.

b. **Laboratory and Pathology Services**. We will provide coverage for diagnostic and routine laboratory and pathology services.

c. **Vision Examinations**. We will provide coverage for diagnostic vision examinations.

d. **Hearing Examinations**. We will provide coverage for diagnostic hearing examinations and evaluations.

e. **Diagnostic Office Visits**. We will provide coverage for office visits to diagnose and treat illness or injury.

f. **Diagnostic Imaging Examinations and Diagnostic Radioactive Isotope Procedures**. We will provide coverage for the professional component of the following procedures, when rendered and billed by a Professional Provider: x-ray examinations; radioactive isotope; ultrasound; computerized axial tomography ("CAT") scan; positron emission tomography ("PET") scan; and magnetic resonance imaging ("MRI").

g. **Radiation Therapy**. We will provide coverage for radiation therapy.

h. **Chemotherapy**. We will provide coverage for chemotherapy.

i. **Dialysis**. We will provide coverage for dialysis treatments of an acute or chronic kidney ailment.

j. **Allergy Testing and Treatment**. We will provide coverage for allergy testing and treatment, including test and treatment materials. Allergy testing includes injections and scratch and prick tests to determine the nature of allergies. Allergy treatment includes desensitization treatments (injections) to alleviate allergies, including allergens.

k. **Mental Health Care**. We will provide benefits for diagnosis and treatment of Mental Illnesses.

l. **Chiropractic Care**. We will provide coverage as outlined in Section 4(B) for services rendered in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. However, such services must be:

i. Rendered by a provider licensed to provide such services; and

ii. Determined by us to Medically Necessary.

m. **Podiatry Care**. We will provide coverage for visits to a podiatrist. Benefits will not be provided for services in connection with nail clipping, corns, calluses, flat feet, fallen arches, weak feet, foot strain, or chronic problems of the feet.

n. **Inpatient and Office Consultations**. We will provide coverage for consultations billed by a physician subject to the limitations below. A consultation is professional advice given by a physician to your attending physician upon request of your attending physician.

i. The physician who is called in is a specialist in your illness or disease;

ii. The consultations take place in a physician's office or while you are a registered bed patient in a Facility;

iii. The consultation is not required by the rules or regulations of the Facility;

iv. The consulting physician does not thereafter render care or treatment of you;

v. The consulting physician enters a written report in your Facility records; and

vi. Payment will be made for only one consultation during any one day unless a separate diagnosis exists.

o. **Injectable Drug**. When drugs are administered by injection during the course of a visit to a Professional Provider covered under this section, you are responsible for the deductible and coinsurance as outlined in Section 4(B).

M. Additional Benefits

1. **Treatment of Diabetes**. We will provide coverage for the following equipment and supplies for the treatment of diabetes that we determine to be Medically Necessary and when prescribed or recommended by your Professional Provider or

other In-Network medical personnel legally authorized to prescribe ("Authorized Medical Personnel"):

a. Insulin and oral agents for controlling blood sugar (limited to a 30-day supply when purchased at a retail pharmacy, or a 90-day supply when purchased at a mail order pharmacy);

b. Blood glucose monitors;

c. Blood glucose monitors for the visually impaired;

d. Data management systems;

e. Test strips for glucose monitors, visual reading and urine testing;

f. Injection aids;

g. Cartridges for the visually impaired;

h. Insulin pumps and appurtenance thereto;

i. Insulin infusion devices; and

j. Additional Medically Necessary equipment and supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Repair, replacement and adjustment of the above diabetic equipment and supplies are covered wen made necessary by normal wear and tear. Repair and replacement of diabetic equipment and supplies made necessary because of loss or damage caused by misuse or mistreatment are not covered.

We will also pay for disposable syringes and needles used solely for the injection of insulin. We will not pay for reusable syringes and needles or multi-use disposable syringes or needles.

We will pay for diabetes self-management education and diet information provided by your Professional Provider in connection with Medically Necessary visits upon the diagnosis of diabetes, a significant change in your symptoms, the onset of a condition necessitating changes in self-management or where re-education or refresher education is Medically Necessary, when such education is provided as part of the same office visit for diagnosis or treatment of diabetes, payment for the office visit shall include payment for the education. We will also pay for home visits when Medically Necessary.

2. **Durable Medical Equipment; External Prosthetic Devices; Orthotic Devices; Medical Supplies; Hearing Aids**

a. **Durable Medical Equipment**. We will provide coverage for the rental, purchase, repair or maintenance of durable medical equipment and for supplies and accessories necessary for the proper functioning of the equipment. We will provide coverage for durable medical equipment that your physician or other licensed/authorized provider and the Plan Administrator determine to be Medically Necessary. The equipment must be the kind that is generally used for a medical purpose, as opposed to a comfort or convenience purpose. We will determine whether the item should be purchased or rented.

Durable medical equipment is equipment that can withstand repeated use; can normally be rented and reused by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a person's home. Examples of covered equipment include, but are not limited to: crutches, wheelchairs (we will not pay for motor-driven wheelchairs unless Medically Necessary), a special hospital type bed, or a home dialysis unit. Examples of equipment we will not cover include, but are not limited to: air conditioners, humidifiers, dehumidifiers, air purifiers, sauna baths, exercise equipment or medical supplies.

No coverage is provided for the cost of rental, purchase, repair or maintenance of durable medical equipment covered under warranty or the cost of rental, purchase, repair or maintenance due to misuse, loss, natural disaster or theft, unless approved in advance. No coverage is provided for the additional cost of deluxe equipment that is not Medically Necessary. We will not provide coverage for delivery or service charges, or for routine maintenance.

3. **External Prosthetic Devices**. We will provide coverage for external prosthetic devices necessary to relieve or correct a condition caused by an injury or illness. We will cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Your physician must order the prosthetic device for your condition before its purchase. Although we require that a physician prescribe the device, this does not mean that we will automatically determine you need it. The Plan Administrator will determine if the prosthetic device is Medically Necessary. We will only provide benefits for a prosthetic device that we determine can adequately meet the needs of your condition at the least cost.

A prosthetic device is an artificial organ or body part, including, but not limited to, artificial limbs and eyes. External prosthetic devices include, for example, the following that are used to replace functioning natural body parts: artificial arms, legs, and eyes; ostomy bags and supplies required for their use; and catheters. Prosthetic devices do not include, for example: hearing aids; eyeglasses; contact lenses; medical supplies; or foot orthotics such as arch supports or insoles, regardless of the Medical Necessity of those items. Dentures or other devices used

in connection with the teeth are also not covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Benefits will be provided for wigs when hair loss is due to a medical condition, such as following chemotherapy or radiation therapy for the treatment of cancer.

Not included in this benefit are: the cost of rental, purchase, repair or maintenance of prosthetic devices because of misuse, loss, natural disaster or theft unless approved in advance by the Plan Administrator. No coverage is provided for the additional cost of a deluxe device that is not Medically Necessary. We will not provide coverage for delivery or service charges, or for routine maintenance related to prosthetic devices.

4. **Orthotic Devices**. We will provide coverage for orthotic devices that are rigid or semi-rigid (having molded plastic or metal stays) when the devices are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. We will cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Orthotic devices include orthopedic braces and custom-built supports. Your physician must order the orthotic device for your condition before its purchase. Although we require that a physician prescribe the device, this does not mean that we will automatically determine you need it. The Plan Administrator will determine if the orthotic device is Medically Necessary. We will only provide benefits for an orthotic device that we determine can adequately meet the needs of your condition at the least cost.

5. **Medical Supplies**. We will provide coverage for disposable medical supplies when you are not an inpatient in a Facility and we determine that a large quantity is necessary for the treatment of conditions such as cancer, diabetic ulcers, surgical wounds and burns. Disposable medical supplies: are used to treat conditions caused by injury or illness; do not withstand repeated use (cannot be used by more than one patient); and are discarded when their usefulness is exhausted. Examples of disposable medical supplies include: bandages; surgical gloves; tracheotomy supplies; and compression stockings. Your physician must order these supplies.

   Not included in this benefit are: supplies that we consider to be purchased primarily for comfort or convenience; delivery and/or handling charges.

   a. **Hearing Aids**. We will provide coverage for hearing aids as prescribed by a physician as set forth in Section 4(B). Over-the-counter hearing aids are not covered by the Plan.

b. **Private Duty Nursing Service**. We will provide coverage for service or care provided by a private duty registered nurse or licensed practical nurse, subject to Medical Necessity, as provided in Section 4(B).

6. **Pre-hospital Emergency Services and Transportation**. We will provide coverage for services to evaluate and treat an Emergency Condition when such services are provided by an ambulance service. We will also provide coverage for land ambulance transportation to a Hospital by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

   a. Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

   b. Serious impairment to such person's bodily functions;

   c. Serious dysfunction of any bodily organ or part of such person; or

   d. Serious disfigurement of such person.

7. **Ambulance Service**. In addition to the services described in **Pre-hospital Emergency Services and Transportation** above, we will also provide coverage for the following Medically Necessary services provided by a certified ambulance service:

   a. Ground or air ambulance service for an urgent condition. When you have an urgent condition, the need for care is less than the need for care of an Emergency Condition, but the condition requires immediate attention. An urgent condition is one that may become an Emergency Condition in the absence of treatment.

   b. Air ambulance service for an Emergency Condition.

   c. Transportation between Facilities.

8. **Care in a Freestanding Urgent Care Center**. We will provide coverage for care at a freestanding urgent care center to treat your illness or condition. We will provide coverage for medical visits of Professional Providers who are not employees or interns of the urgent care center.

9. **Individual Case Management - Alternative Benefits**. If you agree to participate and abide by the policies, in addition to benefits specified in this Plan, we may provide, outside the terms of this Plan, benefits for services, for up to a 60-day period, furnished by any In-Network Provider pursuant to the alternative treatment plan of ours for a Member whose condition would otherwise require hospitalization.

We may provide such alternative benefits if and only for so long as we determine, among other things, that the alternative services are Medically Necessary, cost-effective and feasible, and that the total benefits paid for such services do not exceed the total benefits to which you would otherwise be entitled under this Plan in the absence of alternative benefits.

If we elect to provide alternative benefits for a Member in one instance, it shall not obligate us to provide the same or similar benefits for any Member in any other instance where the alternative treatment is not Medically Necessary, cost-effective and feasible, nor shall it be construed as a waiver of our right to administer this Plan thereafter in strict accordance with its expressed terms.

At the expiration of such 60-day period, you may apply in writing for a continuation of the alternative benefits and services being provided outside the terms of this Plan. Upon such application for renewal, we will review the patient's condition and may agree to a renewal of such alternative benefits and services. Renewals must be in writing and our determination will be final.

The alternative benefits you receive will be in lieu of the benefits we would normally provide to you under this Plan ("the contractual benefits") for the treatment of your condition. As a result, we may require you to agree to waive certain contractual benefits in order to receive the alternative benefits agreed upon. You may return to utilization of contractual benefits at any time upon prior written notice to us. However, the contractual benefits remaining available to you will be reduced in a manner that appropriately reflects the alternative benefits you used.

10. **Novel Coronavirus (COVID-19) ("Coronavirus"):**

a. Effective March 18, 2020, participants and eligible dependents will not be responsible for copayments, coinsurance, or deductibles for: (a) diagnostic tests (approved and authorized by applicable law) for the Coronavirus; and (b) health care provider office visits, urgent care visits, or emergency room visits resulting in testing for the Coronavirus, to the extent such items and services relate to the furnishing or administration of testing or to the evaluation of such individual for purposes of determining the need of such individual for testing. The types of tests that will be covered include:

i. Diagnostic testing authorized by the FDA or the Secretary of HHS;

ii. Diagnostic testing that is under review, or will be submitted for review, by the FDA for emergency use;

iii. Diagnostic testing authorized by a State, if that State has notified the Secretary of HHS; and

iv. Other diagnostic testing authorized under applicable law.

b. Effective March 18, 2020, the Fund waives any preauthorization (or other medical management) requirements for diagnostic tests for the Coronavirus.

c. Over-the-counter Coronavirus tests will be covered to the extent required by applicable law through the Plan's Prescription Drug Benefit.

N. Emergency Care

1. **Eligibility for Benefits**. We will provide coverage as outlined in Section 4(B) for care at the emergency room of an In-Network Provider or Out-of-Network Provider, if your illness or condition is considered an Emergency Condition. We will provide coverage for medical visits of Professional Providers who are not Facility employees or interns to treat an Emergency Condition in an emergency room.

2. **Payment for a Professional Provider's Hospital Emergency Room Visit**. We will provide coverage for visits of Professional Providers if your illness or condition is considered an Emergency Condition. We will not provide coverage for medical visits by Facility employees or interns, even if they are Professional Providers.

O. Human Organ and Bone Marrow Transplants

We will provide coverage for all of the benefits otherwise covered under this Plan for organ and bone marrow transplants subject to the following limits:

1. **Care in Approved Transplant Centers**. Certain types of organ transplant procedures must be performed in transplant centers certified or otherwise approved by the appropriate regulatory authority for the specific type of transplant procedure being performed. The types of organ transplants that must be performed in certified transplant centers are: bone marrow; liver; heart; lung; heart-lung; kidney; and kidney-pancreas. You may contact us if you wish to obtain a list of certified transplant centers.

2. **No Coverage of Experimental or Investigational Organ Transplants**. We will not provide coverage for any benefits for an organ transplant we determine to be experimental or investigational. We maintain and revise from time to time a list of organ transplant procedures which we determine not to be experimental or investigational and that, therefore are covered under this Plan. You may contact us if you have a question concerning whether a particular transplant procedure is covered.

3. **Recipient Benefits**. We will provide coverage for a person covered under this Plan for all of the benefits provided to the recipient of the organ transplant that are otherwise covered under this Plan when they result from or are directly related to a covered organ or bone marrow transplant.

4. **Coverage for Donor Searches or Screenings**. We will not provide coverage for costs relating to searches or screenings for donors of organs.

5. **Costs of Organ Donor**. We will provide coverage for the medical services directly related to the donation of an organ for transplantation to a person covered under this Plan. We will not provide coverage if you are donating an organ for transplantation to a person not covered under this Plan.

P. Exclusions

In addition to the exclusions and limitations described in other sections of this Plan, we will not provide coverage for the following:

1. **Act of War.** We will not provide coverage for any service or care related to an illness or injury that occurs as a result of any war or act of war, whether declared or undeclared.

2. **Blood Products**. We will not provide coverage for the cost of blood, blood plasma, other blood products, or blood processing or storage charges when they are available free of charge in the local area, except we will provide coverage for blood required for the treatment of hemophilia when billed by a Facility. When not free in the local area, we will cover blood charges, even if you donate or store your own blood, if billed by a Facility, ambulatory surgery center, or a certified blood bank.

3. **Certification Examinations**. We will not provide coverage for any service or care related to a routine physical examination and/or testing to certify health status, including, but not limited to, an examination required for school, employment, insurance, marriage, licensing, travel, camp, sport, or adoption.

4. **Cosmetic Services**. We will not provide coverage for any services in connection with elective cosmetic surgery that is primarily intended to improve your appearance and is not Medically Necessary. Examples of the kinds of services that we often determine to be not Medically Necessary include the following: breast enlargement, rhinoplasty and hair transplants. We will, however, provide coverage for services in connection with reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other disease of the part of the body involved. We will also provide coverage for reconstructive surgery because of congenital disease or anomaly of a child covered under this Plan that has resulted in a functional defect. We will also provide coverage for services in connection with reconstructive surgery following a mastectomy as described herein.

5. **Court-Ordered Services**. We will not provide coverage for any service or care (including evaluation, testing, and/or treatment) that is ordered by a court, or that is required by a court as a condition of parole or probation, unless:

a. The service or care would be covered under this Plan in the absence of a court order;

b. Our procedures have been followed to authorize the service or care; and

c. The Plan Administrator determines, in advance, that the service or care is Medically Necessary and covered under the terms of this Plan.

This exclusion applies to special medical reports, including those not directly related to treatment, e.g., reports on certification examinations and reports prepared in connection with litigation.

6. **Criminal Behavior**. We will not provide coverage for any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred.

7. **Custodial Care**. We will not provide coverage for any service or care that is custodial in nature, or any therapy that we determine is not expected to improve your condition. Care is considered custodial when it is primarily for the purpose of meeting personal needs and includes activities of daily living such as help in transferring, bathing, dressing, eating, toileting, and such other related activities.

8. **Dental Care**. Except as otherwise provided in Section 6, "Dental Benefits", the medical benefits offered under the Plan will not provide coverage for any service or care (including anesthesia and inpatient stays) for treatment of the teeth, gums, or structures supporting the teeth; or any form of dental surgery; regardless of the reasons(s) that the service or care is necessary. For example, we will not provide coverage for x-rays, fillings, extractions, braces, prosthetics, correction of impactions, treatments for gum disease, or dental oral surgery. The medical benefits provided under the Plan will, however, provide coverage for medical treatment that is directly related to an injury or accident involving the jaw or other bone structures adjoining the teeth, provided that the treatment is approved by the Plan Administrator. In addition, we will provide the benefits set forth in this Plan for service and care for treatment of sound natural teeth provided within 12 months of an accidental injury. We do not consider an injury to a tooth caused by chewing or biting to be an accidental injury. We will also provide coverage for the services set forth in this Plan that we determine are Medically Necessary for treatment of a congenital anomaly or disease that was evident and observable at birth and caused by a medical condition that was present at birth. We will also provide coverage for the services set forth in this Plan that we determine are Medically Necessary for treatment of cleft palate and ectodermal dysplasia. We will cover institutional provider services for dental care when we determine there is an underlying medical condition requiring these services.

9. **Developmental Delay**. We will not provide coverage for educational services related to evaluation, testing and treatment of behavioral disorders, learning

disabilities, minimal brain dysfunction, development and learning disorders, or developmental delays. We will also not provide benefits for any covered service or care set forth in this Plan when rendered in connection with such conditions, unless Medically Necessary.

10. **Disposable Supplies; Hair Prosthetics; Household Fixtures**. We will not provide coverage for any service or care related to:

    a. Disposable supplies (for example, diapers, chux, sponges, syringes, incontinence pads, reagent strips and bandages purchased for general use); except that this exclusion does not apply to diabetic supplies.

    b. Hair prosthetics, or hair implants (benefits will be provided for wigs when hair loss is due to a medical condition, such as following chemotherapy or radiation therapy for the treatment of cancer); and

    c. The purchase or rental of household fixtures, including, but not limited to, elevators, escalators, ramps, seat lift chairs, stair glides, saunas, whirlpool baths, swimming pools, home tracking systems, exercise cycles, air or water purifiers, hypo-allergenic pillows, mattresses or waterbeds, massage equipment, central or unit air conditioners, humidifiers, dehumidifiers, emergency alert equipment, handrails, heat appliances, improvements made to a house or place of business, and adjustments made to vehicles.

11. **Reversal of Elective Sterilization**. We will not provide coverage for any service or care related to the reversal of elective sterilization.

12. **Employer Services**. We will not provide coverage for any service or care furnished by a medical department or clinic provided by your employer.

13. **Experimental and Investigational Services**. Unless otherwise required by law, we will not provide coverage for any service or care that consists of a treatment, procedure, drug, biological product, or medical device (collectively, "Service"); an inpatient stay in connection with a Service; or treatment of a complication related to a Service; if we determine the Service is experimental or investigational.

    "Experimental or investigational" means that we determine the Service is:

    a. Not of proven benefit for a particular diagnosis or for treatment of a particular condition;

    b. Not generally recognized by the medical community, as reflected in published, peer-reviewed, medical literature, as effective or appropriate for a particular diagnosis or for treatment of a particular condition; or

    c. Not of proven safety for a person with a particular diagnosis or a particular condition, (i.e., is currently being evaluated in research studies to ascertain the

safety and effectiveness of the treatment on the well-being of a person with the particular diagnosis or in the particular condition).

Governmental approval of a Service will be considered in determining whether a Service is experimental or investigational, but the fact that a Service has received governmental approval does not necessarily mean that it is of proven benefit, or appropriate or effective treatment for a particular diagnosis or for a particular condition.

In determining whether a Service is experimental or investigational, we may, in our discretion, require that any or all of the following five criteria be met:

a. A Service that is a medical device, drug, or biological product must have received final approval of the United States Food and Drug Administration (FDA) to market for the particular diagnosis or for your particular condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once final FDA approval has been granted for a particular diagnosis or for your particular condition, use of the Service (medical device, drug, or biological product) for another diagnosis or condition may require that any or all of the five criteria be met.

b. Published, peer-reviewed, medical literature must provide conclusive evidence that the Service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by nonaffiliated, authoritative sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

c. Published, peer-reviewed, medical literature must provide demonstrated evidence that, over time, the Service leads to improvement in health outcomes, i.e., the beneficial effects of the Service outweigh any harmful effects.

d. Published, peer-reviewed, medical literature must provide proof that the Service is at least as effective in improving health outcomes as established services or technology, or is usable in appropriate clinical contexts in which an established service or technology is not employable.

e. Published, peer-reviewed, medical literature must provide proof that improvement in health outcomes, as defined in Subparagraph 3 above, is possible in standard conditions of medical practice, outside of clinical investigatory settings.

This exclusion shall not limit in any way benefits available for prescription drugs otherwise covered under this Plan which have been approved by the FDA for the treatment of certain types of cancer, when those drugs are prescribed for the treatment of a type of cancer for which they have not been approved by the FDA,

so long as the drugs so prescribed meet the requirements of Section 4303(q) of the New York Insurance Law.

14. **Free Care**. We will not provide coverage for any service or care that is furnished to you without charge, or that would have been furnished to you without charge if you were not covered under this Plan. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter, or the spouse of any of such individuals, it will be presumed that the service or care would have been furnished without charge. You must prove to us that a service or care would not have been furnished without charge.

15. **Gene Therapy.** We will not cover any charges related to gene therapy, regardless of whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational. Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. Examples of gene therapy include, but are not limited to, Zolgensma, Luxturna, and Chimeric Antigen T-Cell (CAR-T) Therapies such as Kymriah and Yescarta.

16. **Government Hospitals**. Except as otherwise required by law, we will not provide coverage for any service or care you, your spouse, or your eligible dependent child receive in a Facility or institution which is owned, operated or maintained by: the Veterans Administration (VA); a federal, state, or local government, unless the Facility is an In-Network Provider. However, we will provide coverage for services or care in such a Facility to treat an Emergency Condition. In this case, we will continue to provide coverage only for as long as we determine that emergency care is necessary and it is not possible for you to be transferred to another Facility.

17. **Government Programs**. We will not provide coverage for any service or care for which benefits are payable under Medicare or any other federal, state, or local government program, except when required by state or federal law. When you are eligible for Medicare, we will reduce our benefits by the amount Medicare would have paid for the services. However, this exclusion will not apply to you if you are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. We will not reduce this Plan's benefits, and we will provide benefits before Medicare pays, during the waiting period. We will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before we provide benefits under this Plan.

18. **Hypnosis/Biofeedback**. We will not provide coverage for hypnosis or biofeedback.

19. **Infertility Treatment Services**. We will not provide coverage for the diagnosis and treatment of infertility.

20. **Military Service-Connected Conditions**. We will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration (VA) has the responsibility to provide the service or care.

21. **No-Fault Automobile Insurance**. We will not provide coverage for any service or care for which benefits are available under mandatory no-fault automobile insurance, until you have used up all of the benefits of the mandatory no-fault policy. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy. We will provide benefits for services covered under this Plan when you have exceeded the maximum benefits of the no-fault policy. Should you be denied benefits under the no-fault policy because it has a deductible, we will provide coverage for the services covered under this Plan, up to the amount of the deductible. We will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the mandatory automobile no-fault coverage.

22. **Non-Covered Service**. We will not provide coverage for any service or care that is not specifically described in this Plan as a covered service; or that is related to service or care not covered under this Plan; even when an In-Network Provider considers the service or care to be Medically Necessary and appropriate.

23. **Nutritional Therapy**. We will not provide coverage for any service or care related to nutritional therapy, unless we determine that it is Medically Necessary or that it qualifies as diabetes self-management education. We will not provide coverage for commercial weight loss programs or other programs with dietary supplements.

24. **Personal Comfort Services**. We will not provide coverage for the following service or care that is for personal comfort: radio, telephone, television, or beauty and barber services.

25. **Prescription Drugs**. We will not provide coverage for service or care related to prescription drugs, over-the-counter (nonprescription) drugs, or injections, except for: prescription drugs, and/or injections that are administered to you in the course of a covered outpatient or inpatient treatment in a Facility or Professional Provider's office, or through home health care benefits; or insulin and oral agents for controlling blood sugar.

26. **Prohibited Referral**. We will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray, or imaging services that were provided pursuant to a referral prohibited by law.

27. **Reproductive Procedures**. We will not provide coverage for the following reproductive procedures or services: in vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), cloning, sperm banking and

donor fees associated with artificial insemination or other procedures, or other procedures or categories of procedures excluded by statute.

28. **Routine Care of the Feet**. We will not provide coverage for services related to routine care of the feet, including but not limited to corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, toenails, or symptomatic complaints of the feet.

29. **Self-Help Diagnosis, Training and Treatment**. We will not provide coverage for any service or care related to self-help or self-care diagnosis, training and treatment for recreational, educational, vocational or employment purposes.

30. **Services Covered Under Hospice Care**. If you have been formally admitted to a hospice program and we are providing coverage for your hospice care under this Plan, we will not provide additional coverage under this Plan for any services related to your terminal illness that have been or should be included in our payment to the hospice program for the care you receive. However, should you require services covered under this Plan for a condition not covered under the hospice program, coverage will be available under this Plan for those covered services.

31. **Services Starting Before Coverage Begins**. If you are receiving care on the Effective Date of your coverage under this Plan, we will not provide benefits for any service or care you receive:

    a. Prior to the Effective Date of your coverage under this Plan; or

    b. On or after the Effective Date of your coverage under this Plan, if that service or care is covered under any other health benefits contract, program, or plan.

32. **Special Charges**. We will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claims forms. This exclusion applies to any late charges or extra day charges that you incur upon discharge from a Facility, because you did not leave the Facility before the Facility's discharge time.

33. **Social Counseling and Therapy**. We will not provide coverage for any service or care related to family, marital, religious, sex, or other social counseling or therapy, except as otherwise provided under this Plan.

34. **Transsexual Surgery and Related Services**. We will not provide coverage for surgery, or for any other service or care set forth in this Plan that is related to or leads up to surgery that is designed to alter the physical characteristics of your biologically determined gender to those of another gender, unless Medically Necessary.

35. **Unlicensed Provider**. We will not provide coverage for any service or care that is provided or prescribed by an unlicensed provider; or that is outside the scope of licensure of the duly licensed provider rendering the service or care.

36. **Vision and Hearing Therapies and Supplies**. We will not provide coverage for any service or care related to:

    a. Eyeglasses, lenses, frames, or contact lenses except for the initial prescription for contact lenses or lenses and frames after cataract surgery; and

    b. Vision or hearing therapy, over-the-counter hearing aids, vision training, or orthotics. We will provide coverage for hearing aids prescribed by a physician.

37. **Weight Loss Services.** We will not provide coverage for any service or care in connection with weight loss programs. We will also not provide benefits for any covered service or care set forth in this Plan when rendered in connection with weight reduction or dietary control, including, but not limited to, laboratory services, and gastric stapling, gastric by-pass, gastric bubble or other surgery for treatment of obesity, unless Medically Necessary.

38. **Workers' Compensation.** We will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law. We will not provide coverage for the services even if you do not receive benefits because: a proper or timely claim for the benefits is available to you was not submitted, or you fail to appear at a workers' compensation hearing.

39. **Anti-Amyloid Agents.** We will not provide coverage for anti-amyloid agents including, without limitation, Aduhelm.

    Notwithstanding the foregoing, where it would be required by the No Surprises Act, none of the exclusions in this section will apply to Emergency Services for an Emergency Condition.

Q. Submission of Claims

How to Submit a Claim for Medical Benefits

If Medicare or another health plan is the primary plan, claims should first be submitted to those plans and then to Excellus BlueCross BlueShield with copies of their explanation of benefits or denial.

Claims for services or supplies needed for an illness or injury resulting from an occupational cause, no-fault auto accident, or incident for which benefits could be payable by a third party should be submitted to the appropriate entity. This type of claim is not payable under the Plan. Be sure to advise the provider of these situations to avoid misallocation of benefits. See Section 9(B) herein for details.

In-Network Provider Claims

An In-Network Provider will bill Excellus BlueCross BlueShield directly for benefits. If you are eligible for benefits, you, your spouse or your dependent child need only present your identification card and complete any information requested by the provider. Be sure to give the In-Network Provider full information on other health plans and history of any accidental injuries.

Non-Participating Provider Claims

If you, your spouse, or your dependent child go to an Out-of-Network Provider, ask the provider to submit the claim to their local BlueCross BlueShield Plan. If they will not file the claim, refer to the instructions on the Excellus BlueCross BlueShield claim form for the specific items of information required. A claim form may be obtained from www.excellusbcbs.com or by calling Excellus BlueCross BlueShield at the number on your I.D. card. It is your responsibility to submit a properly completed claim form.

Payment for services rendered by an Out-of-Network Provider that are subject to the surprise billing protections as described in the "Protection from Surprise Bills" section of the Plan will be made directly to the Out-of-Network Provider.

Other Health Claim Submissions

If you are billed for covered services, you must take the following steps to submit a claim for out-of-network benefits:

1. Obtain a claim form from the Fund Office or from Excellus BlueCross BlueShield at their website (www.excellusbcbs.com).

2. Be sure to read the instructions printed on the claim form. **Remember:** You must attach a completed claim form each time you send in medical bills and a separate claim form is needed for each family member.

3. Once you have completed your portion of the claim form, the health care provider can complete his or her portion, if needed, or you may attach itemized bills. If an itemized bill is attached, it must clearly state the patient's name, diagnosis, full description of the service rendered, and an itemized list of charges with dates of service.

4. If services are due to accidental injury, you must provide complete details on how, where, and when such injury was sustained.

5. For services rendered by other than a doctor, the bill should include the provider's signature and tax identification number. Any bill from a nurse must show the date, place and hours of duty, charge per hour, total charge per day and signature, credentials, and registration number.

6. Attach Medicare or other plan explanation of benefits or denial, if appropriate.

7. All completed forms and itemized bills should be submitted to the address on the claim form.

If you fail to provide necessary information, your claim could be returned to you or missing details could be requested which will delay the determination of benefits. Excellus will advise you of approval or rejection of your claim by mailing an Explanation of Benefits.

The Plan's procedures concerning initial determinations, adverse benefit determinations and appeals are set forth in Section 10 of this booklet.

R. Protection from Surprise Bills

A "Surprise Bill" is a bill you receive for a covered service in the following circumstances:

1. Emergency Services performed by an Out-of-Network Provider with respect to an Emergency Condition;

2. Air ambulance services performed by an Out-of-Network Provider; and

3. For certain non-Emergency Services performed by an Out-of-Network Provider at a participating Hospital, ambulatory surgical center and Independent Freestanding Emergency Department.

There are special reimbursement rules that apply to Surprise Bills when determining the Plan's payment to the Out-of-Network Provider. These special reimbursement rules will always apply to the following covered non-Emergency Services when performed by an Out-of-Network Provider at an In-Network Hospital, ambulatory surgical center or Independent Freestanding Emergency Department:

1. Covered services performed by an Out-of-Network Provider when an In-Network Provider is unavailable at the time the healthcare services are performed at the In-Network Hospital, ambulatory surgical center or Independent Freestanding Emergency Department;

2. Covered services performed by an Out-of-Network Provider as a result of unforeseen, urgent medical issues that arise at the time such services are performed, even if you previously consented to the Out-of-Network Provider performing such services;

3. Covered services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;

4. Covered services provided by assistant surgeons, hospitalists, and intensivists; and

5. Diagnostic services, including radiology and laboratory services.

A Surprise Bill does not include a bill for healthcare services when an In- Network Provider is available and you elected to receive services from an Out-of-Network Provider or, with respect to non-Emergency Services (other than those specified above) performed by an Out-of-Network Provider in a participating Hospital, ambulatory surgical center or Independent Freestanding Emergency Department if the Out-of-Network Provider has obtained your consent to receive the services after providing you with required notice and satisfying all other consent requirements applicable to the Out-of-Network Provider. If the Out-of-Network Provider follows the notice and consent requirements and you consent to receiving the services, the Plan's normal reimbursement rules with respect to Out-of-Network Providers will apply with regard to those services and you may be balance billed. Please see the definition of "Allowable Expense" for information about the Plan's normal reimbursement rules.

For Surprise Bills, the Plan will reimburse the Out-of-Network Provider an initial payment equal to the Recognized Amount. You will be held harmless for any Out-of-Network Provider charges for the Surprise Bill that exceed your cost-sharing under the Plan (i.e. Copayment, Deductible or Coinsurance) for In-Network Providers. Your cost-sharing will be calculated based off of the Recognized Amount and will count towards your In-Network Deductible, if any, and your In-Network Out-of-Pocket Maximum.

For purposes of this Section, the "Recognized Amount" means the lesser of the billed charges or the "Qualifying Payment Amount." The "Qualifying Payment Amount" is the amount determined by the Plan in accordance with the requirements of 29 CFR 2590.716-3.

The provisions specified in this section and in the Plan are designed to be consistent with the group health plan requirements of the No Surprises Act. The provisions are based on regulations published by the U.S. Department of the Treasury, Department of Labor, and Department of Health and Human Services (the "Departments") and will be interpreted to be consistent with those regulations.

To the extent the Plan provides coverage for air ambulance or Emergency Services for an Emergency Condition and the cost-sharing applied to such air ambulance services or Emergency Services when rendered by an Out-of-Network Provider is different than the cost-sharing applied when such services are rendered by an In-Network Provider, to the extent necessary to comply with the No Surprises Act, the Plan will apply the same cost-sharing to air ambulance services or Emergency Services for an Emergency Condition when rendered by an Out-of-Network Provider as the cost-sharing that is applied to such services when rendered by an In-Network Provider.

S. Transitional Care

If you are in an ongoing course of treatment when your In-Network Provider leaves the network, then you may continue to receive covered services for the ongoing treatment from the former In-Network Provider for up to 90 days from the date your provider's contractual obligation to provide services to you under the Plan terminates. If you are pregnant, you

may continue care with a former In-Network Provider through delivery and postpartum care directly related to the delivery.

The provider must accept as payment the negotiated fee that was in effect just prior to the termination of the relationship of the provider with the network. The provider must also provide the Plan with necessary medical information related to your care and adhere to any policies and procedures established by the Plan, including those for assuring quality of care and obtaining preauthorization and a treatment plan approved by the Plan. You will receive covered services as if they were being provided by an In-Network Provider and will be responsible only for any applicable cost-sharing.

In addition to the above, if you are considered a "continuing care patient" and any benefits under the Plan are terminated because of a change in the terms of participation of your provider in the network, you will be given notice of such change or termination and will have the right to elect to continue coverage under the Plan, with respect to that provider, under the same terms and conditions that were in effect on the date you are given notice of the provider's change in network status or termination of benefits as a result of change in network participation. If you elect to continue such coverage under the Plan, coverage for transitional care with respect to that provider will be provided under those same terms and conditions only for the period ending on the earlier of (1) 90 days from the date the notice is provided or (2) the date you are no longer considered a "continuing care patient." In addition, coverage under those same terms and conditions during this period of transitional care is limited to the condition for which you were receiving care from your provider, that qualifies you as a "continuing care patient," prior to the provider's change in network status.

For purposes of this section, you are a "continuing care patient" if you meet any of the following conditions:

1. You are undergoing a course of treatment for a "serious and complex condition." For this purpose, "serious and complex condition" means:

    a. An acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

    b. A chronic illness that is life threatening, degenerative, potentially disabling or congenital and requires specialized medical care for a prolonged period of time.

2. You are undergoing a course of institutional or inpatient care from the provider.

3. You are scheduled to undergo non-elective surgery, including post-operative care from the provider.

4. You are pregnant and undergoing a course of treatment for the pregnancy from the provider.

5. You are terminally ill (as defined in Section 1861 of the Social Security Act) and receiving treatment for the terminal illness from the provider.

Please note, if the provider was terminated by the network due to fraud, imminent harm to patients, or a final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment with that provider is not available.

If you have any questions with respect to this section, please contact EBCBS at the telephone number listed on your identification card.

Section 5.
PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are self-funded by the New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund and administered by Express Scripts, Inc.

Express Scripts, Inc. ("ESI")
One Express Way
St. Louis, MO 63121
Telephone: 1-800-939-2108
Website: www.express-scripts.com

A. Your Prescription Drug Benefit Benefits at a Glance

You and your eligible dependents may obtain covered prescription medications for the treatment of a non-occupational injury or illness by presenting your prescription drug identification card and the doctor's written prescription to a pharmacy that participates in the pharmacy network. If you have a question as to whether a pharmacy participates in the program, contact ESI or visit www.express-scripts.com and click "Locate a pharmacy".

The following Benefits are provided subject to the provisions below:

- 80%; Under Retail Card program, insured pays 20% co-pay
- 80%; Under Mail Order program, insured pays 20% co-pay
- Member's maximum expense is capped at $200 per prescription
- Out-of-Pocket Expense Limit does not apply

Medications Covered by the Prescription Drug Program

The following is a summary of the types of drugs covered:

1. Legend drugs
2. Insulin and syringes for its administration, when prescribed by a physician
3. Compounded prescriptions, when the prescription contains at least one federal legend drug in a therapeutic amount(s)
4. Any other drug covered under applicable state laws, which may be dispenses only upon the written prescription of a lawful provider
5. Smoking deterrents available only by prescription, limited to a lifetime maximum of three (3) months
6. Birth control pills and depro provera

7. Legend prenatal vitamins or fluoride vitamins for dependent children up to age 12

8. Certain over-the-counter medications (i.e. Claritin, Claritin D, Prilosec)

9. Diabetic glucose test strips

No Benefits are provided for the following:

The following is a summary of the types of drugs not covered:

1. Immunizing agents

2. Anorexics or weight control medications

3. Fertility drugs

4. Diagnostic supplies

5. Contraceptive devices

6. Rogaine, except when prescribed following chemotherapy treatments of cancer

7. Retin-A in all dosage forms, except when prescribed for the treatment of documented cases of acne vulgaris up to age 25

8. Vitamins, singly or in combination form, except for legend prenatal vitamins, or fluoride vitamins for dependent children up to age 12

9. Any medications not recognized and approved by the Federal Drug Administration, or any medications which do not state: Caution: Federal Law requires a prescription for dispensing of this medication

10. Adderall for individuals age 19 and over

11. Nail fungal treatment

12. Gene therapy, including, but not limited to, all Gene Therapy drugs (for example, Zolgensma, Luxterna, and Strensiq)

B. Preferred Medications

You will be provided with a list of prescription drugs that are preferred by the Fund because they help to control rising prescription drug costs. This list, sometimes called a formulary, offers a wide selection of generic and brand-name medications.

Bring the list of preferred medications with you to each doctor visit to discuss whether a drug on the list is right for you. If you need information about it now, visit ESI at **www.express-scripts.com** or call toll-free at 1-800-939-2108.

C. Utilization Management Program

The Utilization Management Program consists of three components: (A) Coverage Authorization; (B) Preferred Drug Education; and (C) RationalMed and Drug Utilization Review.

Coverage Authorization

1. Prior Authorization Review

Under the prior authorization program, you are required to obtain preapproval before the plan will cover your prescribed medication. The prior authorization may be obtained through a "Traditional Prior Authorization" process or a "Smart Prior Authorization" process. Under the Traditional Prior Authorization process, you, your doctor or your pharmacist may initiate the review process by calling ESI at 1-800-753-2851. Also, when you use **ESI By Mail,** ESI will call your doctor to start the review process. Once the review process is started, your doctor will be sent a Coverage Management Review Fax Form to fill out and fax back to ESI. ESI will send you and your doctor a letter confirming whether or not coverage has been approved.

Under the Smart Prior Authorization process, the authorization is submitted and approved through an automated process known as **Smart Rules**. Upon submission of your prescription to your pharmacist, the prescribed medication is run through the Smart Prior Authorization process. If coverage is not preapproved, you or your pharmacist may request a coverage review by calling ESI at 1-800-753-2851 and, after review, ESI will mail you a notification letter confirming whether or not coverage has been approved.

If coverage is preapproved, your prescription will be filled, and you will be obligated to pay the normal co-pay for the medication. If coverage is not approved, you may still have the prescription filled, but you will be responsible for the full cost of the medication.

You, your doctor or your pharmacist may call ESI at 1-800-753-2851 to find out whether your medication needs preapproval, and if so, whether to use the Traditional or Smart Prior Authorization process.

2. Authorization for Additional Quantity of Medication

For some medications, the plan may only cover a limited quantity within a specified period of time. This program will alert the pharmacist when the total quantity of a medication exceeds the amount allowed. You, your doctor or your pharmacist will need to initiate a coverage review by calling ESI at 1-800-753-2851 to request additional quantities. ESI will send you a notification letter confirming whether or not coverage for the additional quantity has been approved.

You, your doctor or your pharmacist may call ESI at 1-800-753-2851 to determine whether a particular prescription drug is authorized for a limited quantity only.

3. Preferred Drug Step Therapy

The Preferred Drug Therapy Program ("Program") encourages the use of generic medications. The Program targets categories of prescription drugs that are clinically interchangeable and where there are good generic alternatives.

Under the Program, if your doctor writes a prescription for one of the above Target Drugs the request will not be immediately filled. Instead, an ESI representative will have a discussion with your doctor's office regarding the availability of the above Preferred Drugs.

Preferred Drug Education

The Preferred Drug Education Program is a voluntary program. A specially trained ESI pharmacist will contact your treating physician to discuss alternatives when you are prescribed a non-formulary medication to determine whether a less expensive generic or formulary drug may be appropriate to treat your condition. This communication aims to educate the physician on the savings and benefits of utilizing generic or formulary drugs.

For information concerning the Preferred Drug Education program, visit ESI at **www.express-scripts.com** or call toll-free at 1-800-939-2108.

RationalMed and Drug Utilization Review

The RationalMed patient safety program has been a driving force in facilitating coordination of care by leveraging the power of integrated healthcare data to assist physicians in identifying and correcting important therapy-related safety risks.

For information concerning the RationalMed and Drug Utilization Review program, visit ESI at **www.express-scripts.com** or call toll-free at 1-800-939-2108.

D. Your Pharmacy Options

Retail Pharmacies

You may want to use a **participating retail pharmacy** for short-term prescriptions (such as antibiotics to treat infections). Be sure to show your prescription benefit card to the pharmacist and pay your retail co-insurance for each prescription. You may only receive a 30-day supply through a retail pharmacy.

To find a participating retail pharmacy near you:

- Visit **www.express-scripts.com** and click "Locate a pharmacy."
- Ask at your retail pharmacy whether it participates in the ESI network.

If you use a nonparticipating retail pharmacy, you must pay the entire cost of the prescription and then submit a reimbursement claim to ESI. **Reimbursement will be made to you and will be based on the amount that the Fund would be required to pay a participating pharmacy for the medication obtained, less the appropriate Copayment**.

Mail Order Pharmacies

You can enjoy the convenience and savings of having your long-term medications (those taken for 3 months or more) delivered to your home or office. Medications are dispensed by ESI Mail Order pharmacists through a network of mail-order pharmacies.

Mail Order advantages:

- **Get up to a 90-day supply** (compared with a typical 30-day supply at retail) of each covered medication for **just one mail-order payment**.
- **Registered pharmacists** are available 24 hours a day, 7 days a week.
- **Order refills** online, by mail, or by phone—anytime day or night. To order online, register at **www.express-scripts.com**. Refills are usually delivered within 3 to 5 days after ESI receives your order.
- **Choose a convenient payment option**. Caremark offers a safe, convenient way for you to pay for prescription orders called e-check. E-check is an electronic funds transfer system that automatically deducts payments from your checking account. You can also pay by money order, personal check, credit card, or through our automatic payment program. For more information, visit **www.express-scripts.com** or call Member Services.

How to start saving with Mail Order Pharmacies
▪ Obtain a new script from your doctor for up to a 90 day supply (important because if you send in a 30 day script, you will still get charged the 90 day Copayment) ▪ You or your physician's office can call ESI's Customer Service at 1-800-753-2851 and request a Prescription Fax Form. The physician's office must complete the form and fax it back to ESI on the number they provide. This is only authorized when faxed from the physician's office. ▪ If appropriate, your physician may authorize the prescription for a 90 day supply plus refills for up to one year. ▪ Payment Options: (1) put a credit card on file, or (2) send in a check with the prescription for the correct amount of co-pays, or (3) sign up with Customer Service to have the payment electronically withdrawn from your checking account.

Setting up the program can also be done by visiting ESI's website at www.express-scripts.com. For first time users you will need to register**.**

Standard shipping on mail order medications is free of charge and medications will be delivered to your home within eight (8) days after your prescription is received. Expedited shipping is available at an additional charge.

Your medication usually will be delivered within 8 days after ESI receives your order. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when ordering. If you don't have enough, ask your doctor to give you a second prescription for a 14-day supply and fill it at a participating retail pharmacy while your mail-order prescription is being processed.

Specialty Medication Co-Pay Assistance Program

Effective January 1, 2022, the Fund is implementing a specialty medication co-pay assistance program (the "Program"). Under the Program, certain specialty pharmacy drugs are considered non-essential health benefits under the Plan. The specialty drugs currently covered under the Program are set forth in the attached Schedule.[1]

Co-pays for the drugs in the Program will be set to the maximum amount of any available manufacturer-funded co-pay assistance program. However, because the cost of these co-pays will be reimbursed by the manufacturer, you will receive them at no cost. These medications may be filled at your approved specialty pharmacy.

If your specialty medication is on the Program list, you must participate in the Program to receive the medication free of charge, and you must speak with SaveOnSP prior to the first fill under the Program. You can contact SaveOnSP at 1-800-683-1074 for this purpose. If you do not participate in the Program for a specialty medication on the Program list, you will be responsible for a 30% co-insurance payment on the cost of the medication.

In no event will any amount paid related to a specialty medication on the Program list count towards any deductible or out-of-pocket maximum under the Fund.

Specialty Medications not Covered under the Program

Express Scripts utilizes Accredo Health Group, a special care pharmacy, to administer specialty medications not covered under the Program described above to treat some complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether the medication is administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

Under the Plan, some specialty medications not covered under the Program may only be covered when ordered through Accredo. To find out whether any of your specialty medications

[1] Please note that this list is subject to change. Changes to the list will be made available to you. You should also contact SaveOnSp at 1-800-683-1074 to request information about whether your specialty medication is covered under the Program.

need to be ordered through Accredo or whether limitations apply, please call Express Scripts Member Services at 1-800-939-2108.

E. Online Services

If you have Internet access, you can access ESIs website**, www.express-scripts.com**, to**:**

- Compare the cost of brand-name and generic drugs at retail and via mail order.
- Access highlights, as well as health and wellness information.
- Obtain order forms, claim forms, and envelopes.
- Submit mail-order refills.
- Check the status of ESI By Mail orders.

F. General Information

To contact Member Services

Member Services is available 24 hours a day, 7 days a week (except Thanksgiving and Christmas) by calling toll-free 1-800-939-2108. Our Member Services representatives can:

- Help you find a participating retail pharmacy
- Send you order forms, claim forms, and envelopes
- Answer questions about your prescriptions or plan coverage

To access ESI by TTY

TTY is available for hearing-impaired members. Call 1-800-759-1089.

To order prescription labels printed in braille

Braille labels are available for mail-order prescriptions. Call 1-800-939-2108.

Section 6.
DENTAL BENEFITS

Basic and Major Dental Benefits ("Plan") are self-funded by the New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund ("Fund") and administered by Excellus BlueCross Blue Shield

Excellus BlueCross Blue Shield Excellus BlueCross Blue Shield of Central New York, Inc.
333 Butternut Drive
Syracuse, New York 13214
Claims Mailing Address:
P.O. Box 21146
Eagan, MN 55121
Telephone: 1-877-650-5840
Website: https://www.excellusbcbs.com/

The Plan provides for full Basic and Major Dental Benefits with a $1,500 Annual Limit per Individual.

A. Basic Dental Benefits

Basic Dental coverage includes the following services:

1. **Diagnostic**

   a. Oral exams – Initial, Periodic & Emergency Treatment (2 per person per calendar year)

   b. Radiographs – Complete series, Panorex, Periapicals and Bitewings

   Only one complete series or one Panorex X-ray, including any periapicals, per person in any three (3) year period. The Plan allows up to four (4) bitewings in a calendar year.

2. **Preventive**

   a. Dental Prophylaxis (2 per person per calendar year)

   b. Fluoride Treatments (Limited to persons less than age 19 and limited to one treatment per person per calendar year)

   c. Sealants (Limited to person less than age 19, applies to molars and premolars only, and to one treatment per tooth in a three (3) year period)

   d. Space Maintainers (Limited to persons less than age 19 and a total of two (2) per person)

3. Basic Restorative (Fillings)

a. Amalgams (Primary and Permanent teeth)

b. Composite (Primary and Permanent teeth)

4. **Endodontics (Root Canal Therapy)**

5. **Periodontics (Gum Treatment)**

a. Flap entry and closure is part of the allowance for Osseous surgery and Osseous graft and not a separate dental service.

b. Periodontal Maintenance Treatment (2 per person per calendar year following active treatment)

6. Maintenance of Prosthodontics

a. Complete and partial dentures. Any adjustments of or repair to a denture or partial denture within six (6) months of its installation is not a separate covered dental service.

b. Re-cementing a crown or bridge

c. Crown repair

7. **Oral Surgery**

a. Simple Extractions

b. Surgical Extractions

c. Soft tissue Impaction

d. Partial Bony Impaction

e. Complete Bony Impaction

f. General Anesthesia or Intravenous Sedation only allowed in connection with surgical extractions (Nitrous Oxide sedation is not a covered treatment)

Local anesthetic, analgesic and routine post-operative care for extraction and other oral surgery are part of the allowance for each dental service.

Payment for covered services under this Plan is based upon allowable amounts as approved by the Fund. A complete Schedule of Allowances is available from the Fund Office or Excellus BlueCross Blue Shield. You are responsible for any amounts not paid by the Fund.

B. Major Dental Benefits

Major Dental coverage includes the following services:

1. Crowns (Porcelain; porcelain fused to metal, full cast; ¾ cast)

2. Complete Dentures

3. Partial Dentures

4. Fixed Bridges (Abutments and Pontics)

5. Orthodontics (Charges in excess of Plan Allowance are the responsibility of the patient. Lifetime Maximum applies – see Dental Care Limitations in Subsection D)

All services covered under Major Dental Coverage require a Pre-determination of Benefits to be completed prior to the start of any service. See Subsection C below.

Payment for covered services under this Plan is based upon allowable amounts as approved by the Fund. A complete Schedule of Allowances is available from the Fund Office or Excellus BlueCross Blue Shield. You are responsible for any amounts not paid by the Fund.

C. Predetermination of Benefits

A pre-determination of benefits **must** be completed and filed with Excellus BlueCross Blue Shield for a proposed course of treatment for any of the following:

1. Complete Dentures;

2. Partial Dentures;

3. Crowns;

4. Bridgework; or

5. Orthodontic Treatment

It is also recommended that a pre-determination of benefits be submitted for the following procedures:

1. A treatment course which will exceed **$300** in cost;

2. Root canal therapy;

3. Crowns;

4. Periodontal treatment; or

5. Extensive oral surgery.

The Participating Dental Provider must send a written report showing the planned treatment to Excellus BlueCross Blue Shield. An estimate of the Participating Dental Provider's charges must also be submitted. You and your Participating Dental Provider will be notified of any benefits payable within 15 days of receipt of all necessary information.

The pre-determination of benefits evaluation does not guarantee final payment; it is an estimate only. Final payment will be based upon such factors as the actual work completed, patient enrollment eligibility, any primary plan coverage, plan schedule and benefit maximums in effect on the date the services are rendered. A pre-determination of benefits will remain valid for six (6) months from the date of issue.

Alternate Procedure

If Excellus determines that the alternate procedures or an alternate course of treatment can be performed to correct a dental condition, benefits covered under the Plan will be considered for the least costly procedure which Excellus determines:

- is customarily used nationwide for the treatment of the dental condition; and
- are deemed by the dental profession to be appropriate for treatment of the dental condition; and
- meets broadly accepted national standards of dental practice.

If you elect to proceed with the originally proposed course of treatment, benefits are limited to the eligible benefits as determined by Excellus in accordance with the above rules. Additional charges will be your responsibility.

If a treatment plan is not provided to Excellus in advance, benefits will be paid on the basis of the alternate procedures, which would have been proposed had a treatment plan been submitted. This amount may be less than the amount which otherwise would be payable.

D. Dental Care Limitations

1. **Orthodontic Lifetime Maximum**

   Members and Dependents is $1,500.00 per individual.

2. **Clinical Oral Examinations**

   Maximum of two (2) per calendar year.

3. **Radiographs**

   a. Bitewings including up to four (4) films in a calendar year.

b. Panorex including any periapicals once every three (3) years.

4. **Prophylaxis**

a. Routine – Maximum of two (2) per calendar year.

b. Periodontal Maintenance – Maximum of two (2) per calendar year following active treatment.

5. **Fluoride Treatments**

Only to age 19 and limited to one (1) per calendar year.

6. **Space Maintainers**

Only to age 19 and limited to two (2) per person.

7. **Temporary Fillings**

Not Covered.

8. **Pulp Capping/Cement Bases**

These are considered integral parts of the restoration and are not covered per se.

9. **Crown and Gold Fillings**

Limited to one (1) crown per tooth for a period of five (5) years. The Fund will pay for crowns and gold filling only if the tooth cannot be restored.

10. **Extractions**

Routine removal of tooth or a retained root. This fee will include local anesthesia and any necessary x-rays.

11. **Consultation**

Covered **only** for the following specialties: Oral Surgery, Orthodontics, Periodontics and Endodontics. A consultation is not covered on the same day as actual services, except for x-ray examinations.

12. **Periodontal Surgery**

a. Repeated periodontal surgery will not be covered for a period of three (3) years.

b. Periodontal scaling/root planning is allowed once per quad per 12 months.

c. One full mouth debridement is allowed every 12 months.

13. **Oral Surgery**

Fractures are to be verified on request by pre and post-operative x-rays and operative reports. Oral surgery allowances include x-ray films taken solely in connection with the surgery, related local anesthesia and pre and post-operative care. Oral surgery is to be verified on request by pre and post-operative x-rays and operative reports.

14. **Anesthesia**

Anesthesia (including general anesthesia or intervenous sedation) is only covered in conjunction with oral surgery. No coverage is provided for nitrous oxide sedation.

15. **Prosthetics**

Predetermination Required

Duplication (Jump) rebase or chairside reline to a denture, partial or full denture, is limited to one (1) per denture per three (3) year period.

The Fund will not pay for fixed or removable splints for periodontal or other reasons, except when a missing tooth is replaced. Only the portion of the splint replacing the missing tooth will be covered. Splints using enamelite or other similar material replacing missing teeth will not be covered.

The Fund will not pay for the rebase or repair of a newly inserted denture (partial or full) for a period of six (6) months following insertion, nor for the addition of a tooth to replace a natural tooth extracted subsequent to insertion, nor for the addition of a clasp.

The Fund will not pay for replacement of a crown, fixed bridge or denture, which is less than five (5) years old.

Implants are **not covered** and crowns and/or pontics over implants are **not covered**.

The Fund will not pay for crowns or pontics for attachment to or clasp purposes unless that tooth is so broken down it cannot be restored properly by fillings. This also applies to a cantilever pontic when used for attachment reasons for a partial in the same jaw.

The Fund will not pay for dental treatment for cosmetic or aesthetic reasons.

Acrylic crowns must be laboratory processed and permanent, and will only be paid as single crowns (never as bridge abutments or splints). Acrylic crowns will only be covered on the six (6) anterior teeth (cuspid to cuspid).

The Fund does not cover:

16. The replacement or substitution for any type of prosthetic service and appliance, if the Fund made any payment toward the cost of the original installation of such service or appliance, unless five (5) years have elapsed since the Fund's previous payment. This exclusion applies even if additional teeth are involved in the replacement or substitution. All allowances for appliances include adjustment for a period of one (1) year.

17. Secondary or multiple abutments. A second crown or inlay used as a support for the primary crown in connection with fixed bridgework is not covered unless the second supportive crown or inlay was required for the restoration of the tooth.

18. Services or appliances used solely as an adjunct to periodontal care, any dental technique, whether for services or appliances, used in the stabilization of teeth unless there are missing teeth involved in the treatment.

ORTHODONTIC:

Predetermination Required

If the Fund has previously paid for a preliminary appliance, the amount will be deducted from the appliance benefit.

Habit breaking devices or adjustments thereof are **not covered**.

Each period of active monthly orthodontic treatment is considered a separate dental service. Benefits will not be paid for treatment received for orthodontic services after the termination of coverage or for the monthly treatments when an appliance is inserted before a person is eligible for benefits.

E. When Treatment Begins

All dental services will be considered to begin on the date the actual service is performed, regardless of the date the dentist recommended the service.

1. **Dentures or Fixed Bridgework**

   The incurred date for dentures or bridgework is the date the impression is taken, not the date inserted. In situations where more than one impression is taken, the date of the final impression is considered as the date the expense for the denture or fixed bridge is incurred.

2. **Crown**

   The expense for crowns will be deemed incurred on the date the tooth was prepared (filed) for crowning, not the date it was cemented in place.

3. **Root Canal Therapy**

Root canal therapy will be considered incurred on the date the work on each individual tooth began, regardless of the number of canals and the sequence of visits in their treatment. Visits after the effective date of coverage for treatment that commenced prior to the effective date will not be covered. Treatment to a tooth that commenced prior to the termination date of coverage will be covered.

4. **Orthodontia**

Benefits for orthodontic treatment will be provided only for treatment received for an appliance placed after the effective date of these Dental Care Benefits for the individual. The charge for extractions required before appliances are inserted and active treatment begins, will not be regarded as pre-orthodontic care chargeable to the orthodontic maximum. If pre-orthodontic expenses (diagnosis, evaluation, and pre-orthodontic care) are incurred while eligible for benefits, but the first appliance is not inserted until after eligibility terminates, the course of orthodontic treatment will not be considered as having commenced.

F. Payment of Benefits

You have the right to select any licensed dentist for treatment or services. The amount paid by the Fund for covered services is based upon the Schedule of Dental Plan Allowances and is determined by the Board of Trustees. Every service or procedure performed by a dentist is assigned an amount based on the American Dental Association (ADA) procedure code. The Fund will pay the lesser of the amount contained in the Schedule of Dental Plan Allowances or the amount charged by the dentist. The payment made by the Fund will be the same whether a Participating Dental Provider or Non-Participating Dental Provider renders the service.

Participating Dental Providers

A Participating Dental Provider is a dentist who has a signed agreement with the Fund. Participating Dental Providers will accept the Fund's payment as payment in full for covered services. Payments for all covered services will automatically be paid to a Participating Dental Provider. When payment is made to a Participating Dental Provider, you will receive an Explanation of Benefits detailing the payment to the provider. If a service is not covered under the Plan, you are responsible for payment to the Participating Provider for the service.

Excellus BlueCross Blue Shield will provide information concerning Participating Dental Providers. Also, this information will be available on the Fund's website at *www.nytfund.org* , with a link for claim forms and dental providers. As a dental provider's status may change, you should contact Excellus BlueCross Blue Shield to be certain the dental provider is a Participating Dental Provider with the Fund.

Non-Participating Dental Providers

A Non-Participating Dental Provider is a dentist who does not have a signed agreement with the Fund. If services are received from a Non-Participating Dental Provider, you will usually have a balance over and above the amount paid by the Fund for which you will be responsible. When

services are received from a Non-Participating Provider, payment will be made directly to you, unless there is an assignment of benefits.

G. Submission of Claims

When you receive services from a Participating Dental Provider, that provider will submit the claim directly to Excellus. Payment will be made directly to the Participating Dental Provider.

If you are treated by a Non-Participating Dental Provider, you will be billed, or may be required to pay the provider at the time services are rendered. You must complete a claim form and submit this along with an itemized bill to Excellus BlueCross Blue Shield. Follow the directions on the claim form.

If you do not receive an itemized bill, then the Non-Participating Dental Provider must fully complete the dentist's portion of the claim form, and you must then submit the completed form for payment.

All claims for services must be received by Excellus within ninety (90) days from the date the service is rendered. Claims received after the ninety (90) days cannot be considered for payment. However, there is the following exception:

If you have been unable to file a claim with Excellus within ninety (90) days of receiving a covered service because you have filed the claim in a timely manner with another insurance company or plan, which may be responsible for payment of the claim, then you have up to ninety (90) days, from the date of final determination of the claim by the other insurance company or plan, to file the claim with this Plan.

H. Noncovered Services

While the Fund provides benefits for most dental services, you and your dependents are not covered for the following:

1. Cosmetic surgery or cosmetic or aesthetic treatment.

2. Services for which no charge is incurred.

3. Services that are not normally performed according to accepted standards of dental practice.

4. Services that will be covered or partially paid for by No-Fault automobile insurance.

5. Treatment of dental disease, injury or defect arising in the course of any occupation, including volunteer organizations where Workers' Compensation Benefits are provided.

6. Treatment necessitated by war, declared or undeclared.

7. Treatment provided by a dental or medical department maintained by any employer, mutual benefit association, union, trustee or similar type group.

8. Services, supplies or treatment provided by Federal or Local government agency, unless required by law.

9. Replacing stolen, broken or lost prosthetic or orthodontic appliances.

10. Charges for broken appointments or for preparation of claim forms.

11. Implants or crowns or pontics over implants.

12. Educational or training programs or dietary instructions.

13. Experimental procedures.

14. Extra sets of dentures.

15. Supplies necessary for proper dental care.

16. Non-submitted claims or claims more than ninety (90) days after dental work has begun.

17. Replacement of congenitally missing teeth, even if the primary tooth that should have been replaced by that missing tooth is extracted or lost due to other circumstances.

18. Diagnosis or treatment of any form of Temporomandibular Joint Disease or Syndrome.

19. Bleaching or whitening of vital or non-vital teeth.

20. Services for which benefits are provided under any other benefit program or contract with the Fund.

21. Habit breaking devices or adjustments thereof.

22. Procedures not detailed in the Schedule of Dental Plan Allowances.

23. Temporary appliances.

24. Nitrous oxide sedation.

25. The Plan does not cover any service not specifically listed as a covered service by the Plan.

Section 7.
VISION BENEFITS

Vision Care benefits are insured through HM Life Insurance Company and administered by Davis Vision, Inc. ("Davis") under a contract between Davis and the New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund ("Plan").

DAVIS VISION, INC. ("DAVIS")
175 East Houston Street
San Antonio, TX 78205
1-800-328-4728
www.davisvision.com

A. Provision of Plan Benefits

Through its "Davis Network Doctors" (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from a Non-Davis Provider), Davis shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits below as may be Visually Necessary or Appropriate, subject to any limitations, exclusions, or Copayments discussed below.

Copayments for Services Received

The benefits herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Certain Plan Benefits received from Davis Network Doctors and Non-Davis Providers require Copayments. Covered Persons must also follow Benefit Authorization procedures.

Copayments are payable by the Covered Person to Davis Network Doctors at the time services are rendered.

Obtaining Services From Davis Network Doctors

Benefit Authorization must be obtained prior to a your obtaining Plan Benefits from a Davis Network Doctor. When you seek Plan Benefits from a Davis Network Doctor, you must schedule an appointment and identify yourself as a New York State Teamsters Council – United Parcel Service Retiree Health Fund member, so the Davis Network Doctor can obtain Benefit Authorization from Davis. Davis shall provide Benefit Authorization to the Davis Network Doctor to authorize the provision of Plan Benefits to you. Each Benefit Authorization will contain an expiration date, stating a specific time period for you to obtain Plan Benefits. Should the Covered Person receive Plan Benefits from a Davis Network Doctor without such Benefit Authorization, the Davis Network Doctor will be considered a Non-Davis Provider, and the benefits available will be limited to those for a Non-Davis Provider.

Davis shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by Fund and your past service utilization, if any. Any Benefit Authorization so issued by Davis shall constitute a certification to the Davis Network Doctor that payment will be made,

irrespective of a later loss of your eligibility, provided Plan Benefits are received prior to the Benefit Authorization expiration date.

Obtaining Services From Non-Davis Network Providers

When you elect to utilize the services of a Non-Davis Provider for a covered service, benefit payments for the services will not be based on the amount billed, but will be determined according to the Schedule of Benefits below listed under "Non-Davis Provider Benefit," and you are responsible for payment of any additional amounts billed by the Non-Davis Provider. You must pay the Non-Davis Provider in full at the time of service and file a claim with Davis for reimbursement.

You must file notice of a claim with Davis within 20 days after the covered expense is incurred or as soon as reasonably possible. You will then be sent a claim form, which must be completed and sent to Davis with all other necessary information about your expense within 120 days. More information on how to file a claim with Davis is in the Certificate of Insurance.

Obtaining Information Concerning Davis Network Doctors

Covered Persons may obtain further information about the participating status of providers and information on out-of-pocket expenses through www.davisvision.com, or by calling Davis Vision's Customer Service Department at 1-800-999-5431. Davis will provide an updated list of Davis Network Doctors' names, addresses, and telephone numbers twice a year. Covered Persons may also obtain a copy of the Davis Network Doctor directory through contacting Davis' Customer Service Department's toll-free Customer Service telephone line, Davis' website or by written request.

Emergency Vision Care

If vision care is necessary for Emergency Conditions, Covered Persons may obtain coverage under their medical benefit plan, if any.

B. Schedule of Benefits (Premium Platinum Plus)

General

This Schedule lists the vision care benefits to which Covered Persons are entitled, subject to any applicable Copayments and other conditions, limitations and exclusions stated herein. Discounts do not apply for vision care benefits obtained from Non-Davis Providers.

Benefit Period

A twelve (12) month period beginning on January 1 and ending on December 31.

Plan Benefits

SERVICE OR MATERIAL	DAVIS NETWORK DOCTOR BENEFIT	NON-DAVIS PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full	Up to $ 39.00	Available once each twelve (12) months**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	DAVIS NETWORK DOCTOR BENEFIT	NON-DAVIS PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each twelve (12) months**
Single Vision	Covered in full	Up to $23.00	
Bifocal	Covered in full	Up to $37.00	
Trifocal	Covered in full	Up to $49.00	
Lenticular	Covered in full	Up to $60.00	
Choice of plastic or glass lenses	Covered in full		
Oversize lenses	Covered in full	Not covered	
Plan Benefits for lenses are per complete set, not per lens. **Beginning with the first day of the Benefit Period.			

SERVICE OR MATERIAL	DAVIS NETWORK DOCTOR BENEFIT	NON-DAVIS PROVIDER BENEFIT	FREQUENCY
LENS OPTIONS			Available once each twelve (12) months**
Scratch resistant coating	Covered in full	Not covered	
Ultraviolet coating	Covered in full	Not covered	
Standard anti-reflective (AR) coating	$35.00* Member Price	Not covered	
Premium AR coating	$48.00* Member Price	Not covered	
Ultra AR coating	$60.00* Member Price	Not covered	
Blended segment lenses	Covered in full	Not covered	

Standard Progressive addition lenses	Covered in full	Not covered	
Premium Progressive addition lenses	Covered in full	Not covered	
Intermediate vision lenses	Covered in full	Not covered	
High-index lenses	Covered in full	Not covered	
Polarized lenses	Covered in full	Not covered	
Tinted lenses	Covered in full	Not covered	
Polycarbonate lenses	Covered in full	Not covered	
Photochromic lenses	Covered in full	Not covered	
Plastic photosensitive lenses	Covered in full	Not covered	
Scratch Protection Plan Single Vision	$20.00 Member Price	Not covered	
Scratch Protection Plan Multifocal	$40.00 Member Price	Not covered	

SERVICE OR MATERIAL	DAVIS NETWORK DOCTOR BENEFIT	NON-DAVIS PROVIDER BENEFIT	FREQUENCY
FRAMES			Available once each twelve (12) months**
Retail Allowance	$120.00***	Up to $40.00	
Davis Vision Collection-Fashion/ Designer/Premier	Covered in full	n/a	
**Beginning with the first day of the Benefit Period. ***Additional discount applies on overage.			

SERVICE OR MATERIAL	DAVIS NETWORK DOCTOR BENEFIT	NON-DAVIS PROVIDER BENEFIT	FREQUENCY
WARRANTY			
One-year eyeglass breakage warranty	Covered in full	Not covered	

SERVICE OR MATERIAL	DAVIS NETWORK DOCTOR BENEFIT	NON-DAVIS PROVIDER BENEFIT	FREQUENCY
ELECTIVE CONTACT LENSES			Available once each twelve (12) months**
Contact Lenses – Allowance (retail)	$100.00 plus 15% off overage	Up to $35.00	
Contact Lens Evaluation, Fitting Fee & Follow Up (for Davis Vision Collection contact lenses)	Covered in full		
Contact Lens – Davis Vision Collection	Covered in full (includes up to eight (8) boxes of disposable contact lenses) Specialty $60 allowance plus 15% off overage	Not covered	
**Beginning with the first day of the Benefit Period. ***Additional Discount applies to Davis Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.			
Elective Contact Lenses are provided in lieu of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period.			

Plan Benefits Requiring Prior Authorization

The following Plan Benefits are available to Covered Persons subject to review for medical necessity by Davis' Optometric Consultants. If approved, Davis will provide an authorization to the Covered Person's Davis Network Doctor or Non-Davis Provider.

SERVICE OR MATERIAL	DAVIS NETWORK DOCTOR BENEFIT	NON-DAVIS PROVIDER BENEFIT	FREQUENCY
Medically Necessary Contact			Available once each twelve (12) months**
Professional Fees (Contact Lens Evaluation, Fitting	Covered in full	Up to $225.00	

Fee & Follow Up) and Materials			
**Beginning with the first day of the Benefit Period. ***Additional Discount applies to Davis Network Doctor's usual and customary professional fees for contact lens evaluation and fitting.			
Medically Necessary Contact Lenses are provided in lieu of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period.			

SERVICE OR MATERIAL	DAVIS NETWORK DOCTOR BENEFIT	NON-DAVIS PROVIDER BENEFIT	FREQUENCY
Low Vision			
Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for members with low vision. After prior approval by Davis Vision, covered low vision services (both in- or out-of-network) will include: **One comprehensive Low Vision Evaluation every 5 years, with a maximum charge of $300.** This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast, and lighting requirements for optimum vision. **Maximum Low Vision Aid allowance of $600 with a lifetime maximum of $1,200** such as high-power spectacles, magnifiers and telescopes. These devices are utilized to improve the levels of sight, reduce problems of glare, or increase contrast perception, based on the individual's visual goals. **Follow-up care,** four visits in any 5-year period, with a maximum charge of $100 each visit.			

Additional Discount

In addition to the Schedule of Benefits, Covered Persons are eligible for certain discounts, which are negotiated between Davis Network Doctors and Davis Providers. ***NOTE*: *These discounts are not Plan Benefits and are not guaranteed by the Plan nor Davis Vision. These discounts are not provided by Non-Davis Network Providers. Further, not all Davis Network Providers participate in these discounts, and you should call your provider prior to scheduling an appointment to confirm if he or she offers the discount pricing. Neither Davis nor the Plan will be responsible if a provider fails or refuses to give you a discount.***

Discounts for Frames, Spectacle Lenses, and Evaluation & Fittings

A 20% discount is offered for frames and lenses purchased from a Davis Network Provider's own collection (i.e. not the Davis Collection). The full amount of the charge is your responsibility.

A 15% discount is offered for contact lenses and the contact lenses evaluation and fitting from Davis Network Providers. The full amount of the charge is your responsibility.

Discount for Laser Vision Correction

Certain providers will offer a 40%-50% discount off the national average price of traditional LASIK.

Ancillary Product Discount

A 15% courtesy discount is offered from most Davis Network Providers for the purchase of items that either the Plan does not cover or which you are not currently eligible for. Disposable contact lenses are available at a 10% discount.

C. Exclusions and Limitation of Benefits

Benefits will not be paid for charges arising from:

1. Any covered expense not shown in the Schedule of Benefits or any expenses shown as "Not Covered" in the Schedule of Benefits in this booklet or the Certificate of Insurance.

2. Eye examinations required by an employer as a condition of employment except as otherwise provided in the Certificate of Insurance.

3. Services or materials provided in connection with special procedures such as orthoptics and visual training (including but not limited to "Corneal Refractive Therapy" ("CRT"), or "orthokeratology"), or in connection with medical or surgical treatment (including laser vision correction) except as provided herein.

4. Materials which do not provide vision correction, except as provided in the Certificate of Insurance.

5. Charges for the replacement of lost or stolen lenses or frames within the applicable benefit frequency period in the Schedule of Benefits.

6. Sickness or injury for which benefits are provided by a workers' compensation act or other similar legislation.

7. Illness, accident, treatment or condition arising out of war or act of war (declared or undeclared), or while performing service in the Armed Forces or units auxiliary thereto.

8. Illness, accident, treatment or condition arising out of intentionally self-inflicted injury or injury sustained while participating in a felony, riot or insurrection.

9. Services or supplies furnished to a Covered Person before the effective date of his or her insurance under the Plan or after the date a Covered Person's insurance ends.

10. Any medical treatment rendered outside the United States, its possessions, Mexico or Canada.

11. Services rendered by practitioners who do not meet the definition of Provider in the Certificate of Insurance.

12. Expenses covered by any other group insurance.

13. Expenses covered by a health maintenance organization or hospital or medical services prepayment plan available through an employer, union or association.

14. Expenses for which benefits are provided by any other union welfare plan or governmental program or a plan required by law.

15. Comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from Davis or its authorized representative.

16. For Visually Necessary contact lenses prescribed for a Covered Person for which prior approval was not obtained from Davis or its authorized representative.

17. Refraction only claims.

D. Eligibility for Benefits

Eligibility for Vision Care benefits is determined based on the Eligibility criteria discussed in Section 3(A), above.

E. Effective Date of Benefits

Your Vision Care benefits will become effective on the date you have met the eligibility requirements set forth by the Fund.

F. Definitions

The following defined terms apply for purposes of this Section 7:

1. Benefit Authorization: Authorization from Davis identifying the individual named as a Covered Person of Davis, and identifying those Plan Benefits to which Covered Person is entitled.

2. Copayments: Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials provided.

3. Covered Person: A Participant or Eligible Dependent who meets Davis' eligibility criteria and on whose behalf premiums have been paid to Davis, and who is covered under this Plan.

4. Eligible Dependent: Any legal spouse and/or eligible dependent child of a Participant who meets the criteria for eligibility established by the Plan (see Section 3(A) herein) and approved by Davis.

5. Emergency Condition: A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.

6. Davis Network Doctor: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with Davis to provide vision care services and/or vision care materials on behalf of Covered Persons of Davis.

7. Non-Davis Provider: Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with Davis to provide vision care services and/or vision care materials to Covered Persons of Davis.

8. Plan or Fund: The New York State Teamsters Council UPS Retiree Health Fund.

9. Plan Benefits: The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Plan, as defined in the Schedule of Benefits.

10. Participant: An individual who is eligible for coverage as a retiree under the Plan.

11. Schedule Of Benefits: The portion of this document which lists the vision care services and vision care materials which a Covered Person is entitled to receive under this Plan.

12. Medically or Visually Necessary or Appropriate: A service, supply or treatment which is (1) ordered by a provider; (2) required for treatment or management of a medical condition or symptom; and (3) provided in accordance with approved and generally accepted medical and surgical practice.

Section 8.
COBRA CONTINUATION COVERAGE

A. General Information

Note: 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.

When COBRA Continuation Coverage is Available

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event occurs and any required notice of that event is properly provided to the Fund Office, COBRA Continuation Coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." Your spouse and your dependent children (including any child covered pursuant to a Qualified Medical Child Support Order ("QMCSO")) could become qualified beneficiaries and would be entitled to elect COBRA 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 such coverage.

Who is Entitled to Elect COBRA Continuation Coverage

COBRA Continuation Coverage is available to your eligible spouse and dependents <u>if coverage would otherwise end</u> because:

- You divorce or become legally separated from your spouse; or
- Your dependent child ceases to be eligible for Plan coverage (for example, if he or she reaches the maximum age limit for coverage under the Plan).

You Must Give Notice of a Qualifying Event

You or your qualified beneficiaries must inform the Fund Office of certain qualifying events, including divorce, judicial order of legal separation, or your child's loss of status as an eligible dependent. To do this, you or your qualified beneficiaries must use the Fund's notice form, which can be obtained from the Fund Office. 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 event, whichever is later. Failure to give notice to the Fund Office within the time limits may result in your ineligibility for COBRA continuation coverage. The notice should be sent to:

After the Fund Office receives notice of the occurrence of one of the above qualifying events, the Fund 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 Fund 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. You can also request this information at any time by contacting the Fund Office at the above address.

Electing COBRA Continuation Coverage

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage. Retirees may elect COBRA on behalf of their spouses, and parents may elect COBRA on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the COBRA Election Notice will lose his or her right to elect COBRA Continuation Coverage.**

If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. However, you may change your election within the 60-day period described above as long as the completed COBRA Election Form is received by the Fund Office 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.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to, and is actually enrolled in, Medicare benefits or becomes covered under another group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Please note that if you are enrolled in Medicare and elect COBRA Continuation Coverage at a time when you are not actively employed, COBRA Continuation Coverage will be secondary to Medicare.

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end. You will be required to pay for the full cost of such coverage. In addition, if there is a change in the health coverage provided by the Plan to similarly-situated individuals, the same change will be made to your COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage

The amount that your covered spouse and/or dependent children will be required to pay for COBRA Continuation Coverage will be payable monthly. The Plan charges the full cost of coverage for similarly situated participants and beneficiaries who have not lost coverage under the Plan, plus an additional 2% (for a total charge of 102%).

The Fund Office will notify you of the cost of the coverage and of any monthly COBRA premium charges at the time you receive your notice of entitlement to COBRA Continuation Coverage. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Your first payment for COBRA Continuation Coverage does not have to be sent with the COBRA election form. However, the first payment must be made no later than 45 days after the date of the COBRA election. (This is the date that the Election Notice is post-marked, if mailed). Coverage will not be effective until payment is received. **Failure to make the first payment for COBRA Continuation Coverage in full within 45 days after the date of the COBRA election will result in the loss of all COBRA Continuation Coverage rights under the Plan. Once COBRA Continuation rights are terminated, they cannot be reinstated.**

After the first payment is received, payments are due on the first day of each month. There will then be a grace period of 30 days in which to make the payment. Please note that your coverage will be suspended and claims will not be paid until a payment is made to the Fund Office. However, once payment is received, your coverage will be reinstated retroactive to the first day of the month.

If payment of the applicable COBRA Continuation Coverage premium is not made by the end of the applicable grace period, COBRA Continuation Coverage will terminate. Once COBRA Continuation rights are terminated, they cannot be reinstated.

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, Medicaid, 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.*Duration of COBRA Continuation Coverage*

COBRA Continuation Coverage is available for your eligible spouse and dependent children as follows:

COBRA Continuation Coverage is available if coverage would otherwise be lost because:	For up to:
Your dependent child ceases to be eligible for coverage under the Plan.	36 months from the date the child becomes ineligible under the terms of the Plan.

You divorce or legally separate from your spouse.	36 months for your spouse and eligible dependent children from the date of divorce or legal separation.

When COBRA Continuation Coverage Ends

Once COBRA Continuation Coverage has been elected, it may be terminated prior to the exhaustion of the 36-month COBRA Continuation Coverage period, as a result of the occurrence of any of the following events:

- The premium for coverage is not paid in a timely manner;
- The Plan ceases to provide group health coverage;
- After electing COBRA Continuation Coverage, the qualified beneficiary becomes covered by another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have; and/or
- After electing COBRA Continuation Coverage, the qualified beneficiary enrolls in Medicare.

B. Address Changes

In order to protect your family's rights, you should keep the Fund Office 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 Fund Office

C. Contact Information

New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund
P.O. Box 4928 Syracuse, NY 13221-4928
Phone: 315.455.9790 Fax: 315.455.1237
Toll Free: 877.698.3863

Section 9.
PROVISIONS AFFECTING ALL FUND BENEFITS

A. Coordination of Benefits

Coordination of Benefits applies if you or your dependent spouse is covered under a separate group benefits plan in addition to this one. Coordination of Benefits applies to Medical Benefits, Prescription Drug Benefits, Dental Benefits and Vision Benefits.

1. **Other Programs Subject to the Coordination of Benefits Rules.** The Plan coordinates benefits with the following group programs, whether insured or self-insured:

   a. A Blue Cross or Blue Shield Plan group contract;

   b. Group or group remittance insurance contracts;

   c. HMO's and other prepayment group practice and individual practice plans;

   d. Labor-management, union, employer organization or employee benefits plans;

   e. Blanket contracts, except school accident or similar coverage where the organization pays the premium;

   f. A governmental program for hospital, medical, and surgical benefits offered, required, or provided by law, except Medicare and Medicaid. (It does not include a program whose benefits, by law, are in addition to any private or non-governmental health benefits program.); or

   g. Health coverage in group and individual mandatory automobile "no fault" and traditional mandatory automobile "fault" type contracts. The Fund will not coordinate benefits in those instances where driving while intoxicated or driving under the influence is involved, unless the individual has exhausted all optional benefits for these situations under any automobile insurance coverage.

2. **Purpose.** Coordination of Benefits (COB) means that the coverage provided by us is coordinated with coverage available to you under another health benefits program. The purpose of COB is to avoid both programs paying benefits for the same services.

3. **Payment Rule.** When you are covered by the Fund and another benefits program, you have primary and secondary coverage. Primary coverage means the program that is required to pay its benefits first. Secondary coverage means the program paying second.

In deciding which program is primary, we will use the first of the following rules that applies:

a. If a program does not have a COB provision like this one, it is primary.

b. The Plan that covers the patient as a current employee is always primary.

c. If a child is covered as a dependent of two people, (parents/married or joint custodians of the child without a court decree establishing financial responsibility for health care expenses), under different programs the following rules apply:

    (1) The program of the parent whose birthday (month and day) is earlier in the year is primary subject to the provisions of Section 3(A) (Initial Eligibility and Coverage) relating to "Opt Out" provisions for spouses' coverage;

    (2) If both parents have the same birthday, the program which covered a parent longer is primary subject to the provisions of Section 3(A) (Initial Eligibility and Coverage) relating to "Opt Out" provisions for spouses' coverage; however,

    (3) When another program has not adopted the birthday rule, and the two plans do not agree which program is primary, the program which has covered a parent longer is primary subject to the provisions of Section 3(A), (Initial Eligibility and Coverage) relating to "Opt Out" provisions for spouses' coverage;

    (4) If the parents are divorced or legally separated, and joint custody has not been decreed, the special rule in (d) may apply.

d. For children of divorced or separated parents the following rules apply:

    (1) If there is a court decree establishing financial responsibility for the health care expenses of the child of divorced or separated parents and the program has actual knowledge of the court decree, the program which covers the child as a dependent of the parent with financial responsibility will be primary.

    (2) If the program has no actual knowledge, the following rules apply.

        i. If the parents are divorced or separated, the program which covers the child as a dependent of the parent with custody is primary; provided the parent with custody has not remarried.

ii. If the parents are divorced and the parent with custody of the child has remarried, the primary program is the first of the following to apply:

a. The program which covers the child as a dependent of a parent with custody,

b. The program which covers the child as a dependent of the spouse of the parent with custody, or

c. The program which covers the child as a dependent of the parent without custody.

(3) If the court decree states that the parents have joint custody and fails to specify which parent has responsibility for health care expenses of the dependent child, the program of the parent whose birthday (month and day) is earlier in the year is primary. If both parents have the same birthday, the program which covered a parent longer is primary.

e. When the above rules do not determine priority, the program that covered the Participant for the longest time is primary. The other program is secondary. Except that:

(1) The program in which the Participant is covered as an employee, but not as a laid-off or retired employee or the dependent of such an employee, is primary;

(2) The program in which the Participant is covered as a laid-off or retired employee or the dependent of such an employee is secondary; and

(3) If both programs do not have a provision like this for laid-off or retired employees, then the above will not apply.

4. **How COB affects payments.**

a. **When the Fund is primary.** The Fund will pay for services covered as if there is no COB provision.

b. **When the Fund is secondary.** The Fund bases its payments, when it is secondary, on allowable expenses during a claim determination period. Allowable expenses are the necessary, reasonable, and customary items of expense for health care which are covered at least in part by one or more health benefit programs. Items of expense are money payments made or the value of service given to you or on your behalf. A claim determination period means a calendar year. It does not include any part of a year when you were not covered

by this program. The Fund will pay for covered services after the payment by the primary program. Benefits may be reduced by the Fund so the total of all benefits available to you from the Fund and the primary program is not more than the allowable expenses.

The Fund counts as actually paid by the primary program any items of expense which would have been paid if you had made the proper claim. If the primary program claims it is "excess only" or "always secondary", the Fund may request information from that program so the Fund can process your claim. If the primary program does not respond within thirty **(30)** days, the Fund will assume its benefits are the same as those offered by the Fund. If the primary program sends the information after thirty **(30)** days, the Fund may adjust its payment if necessary. When the Fund is secondary, it will never pay more than the full amount of benefits due under the Fund had it been primary.

5. **Right to receive and release necessary information.** Where permitted by law, the Fund may release to, or obtain from, any person, company or organization information which the Fund believes is necessary to carry out the purposes of this Section. The Fund's privacy policy is detailed in Section 11 of this booklet. The Fund will not be legally responsible to anyone for releasing or obtaining information. You must furnish us any information that the Fund requests. If you do not furnish the information requested, the Fund reserves the right to deny benefits until you do.

6. **Payments to other health benefit programs.** The Fund may repay to any other health benefit program the amount that it paid for your covered services if:

   a. The Fund determines that it should have paid.

   b. Your claim was timely filed with the Fund.

   These payments are the same as benefits paid to you and they satisfy the Fund's obligation to you.

7. **The Fund's right to recover payment.** In some cases, the Fund has made payment even though you had coverage under another program. If this happens, you must refund the amount of the Fund's payment. The Fund also has the right to recover payment from the other program. You must sign any document we feel is needed to help recover our payment. For more information about the Fund's reimbursement and subrogation rights, please review Subsection B below.

8. **Obligation to comply with Primary Plan.** In the event you or your covered dependent fails or refuses to comply with the terms and conditions of another plan, or fails to file a claim with another plan, thereby resulting in that other plan reducing or denying benefits, the Fund will only provide benefits under the Coordination of Benefits provision based upon the benefits which the other plan would have provided if you or your covered dependent had fully and properly complied with

the terms and conditions of the other plan, including filing of necessary claim forms and proof of expenses incurred.

B. Claims Involving Third-Party Liability (Reimbursement and Subrogation)

In cases where a third party is responsible for causing illness or injury to you or your dependent, that third party may be liable for the resulting medical expenses. This Fund does not cover expenses for which some third party is responsible. When that happens, you or your dependent must immediately notify the Fund Office of the circumstances and agree to reimburse the Fund out of any recovery which you or your dependent receive. For this provision, "recovery" broadly refers to any monies, damages or benefits that you or your dependent receive from a third party through lawsuit, workers' compensation award, insurance recovery, judgment, settlement or any other payment that relates to the illness or injury you or your dependent have suffered.

These rules have two purposes. First, they insure that your expenses (and your dependent's expenses) will be paid timely by the Fund. Otherwise, payment of your expenses may be delayed for many months until the third party is found to be liable for them. Second, these rules protect this Fund from bearing the full expense in situations where a third party is liable. This helps to keep down the cost of the premiums that participants must pay for coverage from this Fund.

If you or your dependent incurs medical or other covered expenses for which a third party may be liable, you or your dependent must immediately notify the Fund Office. Also, if the Fund Office requests it, you must promptly provide the Fund Office with any information and documents that may be related to such third-party recovery, claim or legal action. You and your dependents agree that the Fund automatically acquires any and all rights which you or your dependent may have against the third party. In addition, the Fund has the right to be reimbursed for payments made on behalf of you or your dependent under these circumstances. The Fund must be reimbursed from any recovery that you or your dependent obtains from the liable third party before any other expenses, including attorneys' fees, are taken out of the recovery.

As such, if you or your dependent becomes ill or is injured and a third party may be responsible for the illness or injury or a third party may be responsible for paying damages or benefits related to the illness or injury, the Fund may advance payment of benefits on behalf of you or your dependent, but only under the following conditions:

- The Trustees may, in their sole discretion, require you or your dependent to execute the Fund's lien forms before the Fund will pay any benefits related to those expenses. If the Trustees have required execution of the Fund's lien forms, no benefits will be provided unless you or your dependent and your (or your dependent's) attorney, if any, sign the forms. You or your dependent also must notify the Fund before retaining another attorney or an additional attorney since that attorney must also execute the forms. IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORMS DIMINISH OR BE CONSIDERED A WAIVER OF THE FUND'S RIGHT OF SUBROGATION AND REIMBURSEMENT.

- If you or your dependent recovers money from a third party related to an illness or injury for which the Fund has paid benefits, you or your dependent must repay the Fund for the

benefits it paid out on behalf of you or your dependent, up to the amount of the recovery. For example, if the Fund pays out $15,000 in medical claims on your behalf, and you later recover $25,000 from the third party responsible for your injury, you must reimburse the Fund for the $15,000 of medical benefits that it paid on your behalf. In addition, if the third party recovery is less than the full amount of damages or expenses that you or your dependent claim, the Fund's share of the recovery will not be reduced and will remain the full amount of the benefits the Fund has paid on your behalf, unless the Fund agrees in writing to a reduced amount.

- This repayment obligation applies to any recovery from a third party, regardless of how the recovery is structured and regardless of whether the payment is characterized as compensation for medical expenses, pain and suffering or something else.

- The Fund has a specific and first right of reimbursement out of the proceeds of any recovery to you or your dependent. That means that you or your dependent's obligation to repay the Fund has priority over other obligations you or your dependent may have, including any obligation to pay attorneys' fees out of the recovery. You or your dependent may not reduce the amount you or your dependent owes the Fund to account for the payment of attorney's fees or other obligations.

- Once Fund benefits are paid, the Fund has a lien on the proceeds of any recovery from a third party received by you (or on your behalf) or your dependent (or on his/her behalf). Therefore, you and your dependent consent and agree that a lien or an equitable lien by agreement in favor of the Fund exists with regard to any recovery from a third party. In addition, you grant the Fund an irrevocable vested future interest in the proceeds of any recovery from a third party that is predicated on an illness or injury for which Fund benefits were paid to you or your dependent. You also agree that once you or your dependent receive a recovery, you and your dependent are responsible for holding and safeguarding the Fund's funds in a constructive trust until those funds are surrendered to the Fund. You and your dependent will act as the trustee and fiduciary of the Fund's funds, and you and your dependent may be liable for your failure to safeguard those funds.

- In accordance with the lien described in the paragraph above, you and your dependent agree to cooperate with the Fund to effect the Fund's reimbursement or subrogation rights, including but not limited to reimbursing the Fund for its costs and expenses. You or your dependent also agree not to do anything that may impair, prejudice or discharge your right to recover from a third party and/or the Fund's right to reimbursement or subrogation, including but not limited to settling any claim or lawsuit without the written consent of the Fund.

- You and your dependent may not assign any rights or causes of action that you may have against any third-party tortfeasors without the express written consent of the Fund. The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Fund, and you and your dependent agree and consent that the Fund may bring an action or claims against a third party in your place (or in place of your dependent) to recover the paid Fund benefits. If this Fund recovers from the third party any amount in

excess of the benefits paid plus the expenses incurred in making the recovery (including the Fund's attorney's fees), the excess will be paid to you or your dependent.

- The Fund's rights of subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault, the common fund doctrine, the attorney fund doctrine, or any other defenses or doctrines that may affect the Fund's recovery.

If you or your dependent fail to inform this Fund that you or your dependent have a claim against a third party; fail to assign your claim or your dependent's claim against the third-party to this Fund when required to do so (and to cooperate with the Fund's subsequent collection efforts); fail to require any attorney that you or your dependent retain at any time to sign the Fund's liens forms; if you, your dependent and/or your attorney fail to reimburse the Fund out of any recovery obtained from the third party; and/or you or your dependent fail to fully reimburse the Fund out of any settlement received even if this Fund reduces the amount of its lien or otherwise limits its rights, then you or your dependent are personally liable to this Fund for the reimbursement owed to this Fund out of the third party recovery plus ten percent (10%) per annum, as well as for the Fund's attorneys' fees and costs incurred in recovering that amount. The Fund may offset the amount owed from any future benefit claims or, if necessary, take appropriate legal action against you or your dependent.

In addition to satisfaction of its existing lien from any recovery which you or your dependent receive, the Fund is also entitled to a future credit for related medical expenses equal to the net monies that you receive. As such, you or your dependent must spend your net recovery on related medical expenses until the amount of that net recovery is exhausted. Only then will your further related medical expenses again be the financial responsibility of the Plan. The Fund Office will determine the net monies available for a future credit.

C. Return of Overpayments or Mistaken Payments

In the event that a participant or a third party is paid benefits from the Plan in an improper amount or otherwise receives Plan assets not in compliance with the Plan (hereinafter referred to as overpayments or mistaken payments), the Plan has the right to start paying the correct benefit amount. In addition, the Plan has the right to recover any overpayment or mistaken payment made to you or to a third party. The claimant, third party, or other individual or entity receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment to the Plan with interest at 9% per annum. Such a recovery may be made by reducing other benefit payments made to or on behalf of you or your spouse or dependents, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate. The claimant, third party, or other individual or entity shall reimburse the Plan for attorneys' fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Plan in attempting to collect and in collecting the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

Section 10.
CLAIMS AND APPEAL PROCEDURES

A. Initial Decisions and Adverse Benefit Determinations

The "initial decision" is the first notice you will receive from the Fund as to whether your benefits claim is covered by this Fund. If the initial decision indicates that your claim for benefits is denied, or is not fully covered, that decision is known as an "adverse benefit determination."

More specifically, an adverse benefit determination is: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such decision that is based on the participant's, dependent's or beneficiary's eligibility to participate in the Fund; and (2) a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

B. Procedures for Making Initial Decisions

Medical Benefits **(Administered by Excellus BlueCross Blue Shield),** ***Dental Benefits*** **(Administered by Excellus BlueCross Blue Shield), and** ***Prescription Drug Benefits*** **(Administered by Express Scripts, Inc.)**

For these Medical Benefit Claims, the rules that apply depend on whether the claim is a Pre-Service Claim, Urgent Care Claim, Concurrent Care Claim, and/or Post-Service Care Claim. Each of these types of Claims and the rules related to them are described below.

Pre-Service Claims

A Pre-Service Claim is any claim with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. The only possible Pre-Service Claims are claims for Medical Benefits administered by Excellus BlueCross Blue Shield, Dental Benefits administered by Excellus BlueCross Blue Shield and Prescription Drug Benefits administered by Express Scripts, Inc.

For Pre-Service Claims, you will be notified of the benefit determination by, Excellus BlueCross Blue Shield (medical and dental) or Express Scripts, Inc., the third-party administrators (whether adverse or not), within a reasonable period, but not later than 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days for matters beyond the Plan's control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and of the date by which the third-party administrator expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the information that you need to provide and you will have 45 days from receipt of the notice to provide the specified information. A decision will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information. In addition, if the claim is improperly filed, the third-party administrator will provide notice of the failure within 5 days.

Urgent Care Claims

An Urgent Care Claim is a Pre-Service Claim for medical care or treatment that is time sensitive. In particular, an Urgent Care Claim is one in which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. The only possible Urgent Care Claims are claims for Medical Benefits administered by Excellus BlueCross Blue Shield, Prescription Drug Benefits administered by Express Scripts, Inc. and Dental Benefits administered by Excellus BlueCross Blue Shield.

For Urgent Care Claims, you will be notified by the third-party administrators regarding the benefit determination (whether adverse or not) as soon as possible, and not later than 72 hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. You will be provided a reasonable amount of time to provide the specified information, but not less than 48 hours. Notification of the decision on that claim will then be provided within 48 hours after the earlier of third-party administrator's receipt of the specified information or the end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within 3 days of the oral notification.

Post-Service Claims

A Post-Service Claim means any claim that is not a Pre-Service claim, (i.e., prior Plan approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant). Certain claims for Medical Benefits, Prescription Drug Benefits and/or Dental Benefits administered are Post-Service Claims.

For Post-Service Claims, you will be notified of any adverse benefit determination by Excellus BlueCross Blue Shield (the third-party administrator for Medical Benefits), Excellus BlueCross Blue Shield (the third-party administrator for the Dental Benefits), or Express Scripts, Inc. (the third-party administrator for the Prescription Drug Benefit) within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended by 15 additional days for matters beyond the Plan's control if, before the end of the initial 30-day period, the third-party administrator, notifies you of the reasons for the extension and of the date by which it expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days from receipt of the notice to provide it. A determination will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information.

Concurrent Care Claims

A Concurrent Care Claim is a claim involving a pre-approved, ongoing course of treatment, including a request for extension of a course of treatment. The only possible Concurrent Care Claims are claims for Medical Benefits and Dental Benefits both of which are administered by Excellus BlueCross Blue Shield.

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment is an adverse benefit determination. You will receive notice of such an adverse determination from Excellus BlueCross Blue Shield (medical and dental) sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the reduction or termination occurs. Also, for any request to extend an urgent care ongoing course of treatment beyond the initially prescribed period of time, you will be notified of the determination (whether adverse or not) within 24 hours after receipt of the claim, as long as the claim is made at least 24 hours before the end of the initially prescribed period of time or number of treatments.

Examinations

The third-party administrator or its designee shall have the right to have a physician of its choice examine you during the pendency of a claim as often as is reasonable under the circumstances. Failure to appear for such examination shall bar any further payment of Fund benefits.

Prescription Drug Benefit

Claim forms are not needed to obtain prescription benefits. To request prescription benefits you simply present your card and prescription to the pharmacist. That request is not considered a "claim" under these procedures. However, if your request is denied in whole or in part, you may file a claim for benefits by submitting your paid receipts for the prescription drug, along with a completed claim form, to Express Scripts, Inc. at the following address:

P.O. Box 69
Lee's Summit, MO 64063-0069

If you need a claim form, or have any questions regarding these procedures, please call the Fund Office at 315.455.9790.

Vision Care Benefits (Administered by Davis Vision)

The Vision Care Benefit's claims procedures are set forth in the Certificate of Insurance provided by HM Life Insurance Company of New York which is incorporated herein by reference.

C. Notice of Adverse Benefit Determinations

If you receive notice of an adverse benefit determination, it will contain the following information:

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. In the case of an adverse determination involving the claim for urgent care, a description of the expedited review process applicable to such claims;

6. If an internal rule, guideline, or protocol was relied upon in making the adverse determination with regard to medical, the rule, etc., or a statement that the rule was relied upon and that a copy of it will be provided free of charge upon request; and

7. If an adverse benefit determination under the medical benefits 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.

D. Appeals of Adverse Benefit Determinations

If you are not satisfied with the reason or reasons for your adverse benefit determination, you may appeal the 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. The Trustees (or their third-party administrator) will not be able to communicate with someone else about your claim unless you have provided written notice that that person is your chosen representative.

E. Procedures for Appeals

Time Frame For You To File An Appeal

Medical, Dental and Prescription Drug Benefit Claims:

To appeal an adverse determination of a Medical Benefit, Dental Benefit or Prescription Drug Benefit, you must file your appeal with the third-party administrator within 180 days after you receive the initial adverse benefit determination. For Medical, Dental and Prescription Drug claims other than Urgent Care claims, the Plan employs a two-level appeal process. If you have your first level appeal of a Medical claim denied, to appeal to the second level of appeal, you must file your second-level appeal with the Board of Trustees within 45 days from the date of the letter of denial of your first-level appeal.

Excellus BlueCross Blue Shield (medical and dental) or Express Scripts, Inc. will decide first level of appeals for Pre-Service and Post-Service claims. The appropriate third-party administrator will decide all appeals of Urgent Care claims and the second level of appeal on any Pre-Service and Post-Service claims.

Notwithstanding anything in this paragraph to the contrary, for Concurrent Claims involving a reduction or termination of a pre-approved, ongoing course of treatment, you will have 180 days to appeal to Excellus BlueCross Blue Shield, with respect to Concurrent Medical Benefit Claims, to Excellus BlueCross Blue Shield, with respect to concurrent Dental Benefit Claims, or to Express Scripts, Inc., with respect to concurrent Prescription Drug claims.

Special Rule Regarding Urgent Care Claims: If Urgent Care Claims are involved, you may request an expedited appeal, either orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan or the third-party administrator by telephone, facsimile, or other similarly expeditious method. Further, if the appeal involves an Urgent Care Claim, a health care professional with knowledge of your medical condition, such as your treating physician, will be permitted to act as your authorized representative.

Vision Care Benefit Claims:

The Vision Care Benefit's appeals procedures are set forth in the Certificate of Insurance Provided by HM Life Insurance Company of New York which is incorporated herein by reference.

GUIDELINES FOR APPEALS

For appeals to the Board of Trustees, your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED ____, 20____." 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, all appeals must adhere to the following criteria: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the appropriate named fiduciary of the Plan 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, will be identified.

Time Frames for Plan to Determine Appeals

Pre-Service and Concurrent Claims for Medical, Dental and Prescription Drug Benefits: These Medical Benefit claims are subject to a two-level appeal process, as noted above. At the first level of appeal, Excellus BlueCross Blue Shield (medical and dental), or Express Scripts, Inc., the third-party administrators, will notify you of the decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review. If your first-level of appeal is denied and you appeal at the second level to the Board of Trustees, the Board of Trustees will notify you of the decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

Urgent Care Claims: The third-party administrator Trustees will decide and communicate to you its decision on appeal as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review.

Post-Service Claims for Medical, Dental and Prescription Drug Benefits: These Medical Benefit claims are subject to a two-level appeal process, as noted above. At the first level of appeal, Excellus BlueCross Blue Shield (medical and dental) or Express Scripts, Inc. will notify you of its determination on appeal within 30 days of receipt of the appeal. If your first-level appeal is denied and you appeal to the second level to the Board of Trustees, the Board of Trustees will also notify you of its determination on appeal within 30 days of receipt of the appeal.

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 conditions on a finding of disability by a part 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 advise 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.

F. Notice of Determination of Appeal

The Plan's written notice of its appeals decisions 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 you, as the claimant, are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

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 your medical circumstances, or a statement that such explanation will be provided upon request.

F.1 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 subsection Q, titled "Protection from Surprise Bills," in the Major Medical Benefits section of this SPD booklet.

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 Major Medical Benefits section of this 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.

<u>Coverage Determinations Subject to External Review</u>

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 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 have agreed 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 the subsection titled "Protection from Surprise Bills" in the Major Medical Benefits section of this 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.

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.

H. Definitions

For purposes of handling claims submitted to the Fund or its third-party administrator, words or phrases shall have the following meanings:

1. Claim

A Claim is a written or electronic request for a Fund benefit, or written or electronic request for pre-certification for a hospital admission or other benefit, received by the Fund or its third-party administrators.

2. Receipt of Claim

A Claim is considered received by the Fund or its third-party administrator when the request contains enough information to permit determination of eligibility of the person seeking the benefit; adequate information of the activity involved to determine if the service or event is covered by the Fund; sufficient information, or authorization to obtain information, to permit the Fund to make the dollar payment to the appropriate party. A verbal request for coverage will be considered received on the day of the conversation only if a written claim is received by the Fund or its third-party administrators within 48 hours of the time of conversation.

3. Authorized Representative

Is a person or organization that provides documentary evidence to the Fund that he, she or it has been authorized to act on behalf of a Participant, Dependent or Beneficiary with respect to a claim or appeal of an adverse benefit determination regarding a claim. Documentary evidence may be in the form of a written authorization (or letter) from the Participant, Dependent or Beneficiary, power of attorney forms, or other documentation issued by the courts (such as guardianship documentation).

Section 11.
HIPAA

This section addresses how information about you may be used and disclosed, and how you obtain access to this information.

A. Uses and Disclosures of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996, as amended, ("HIPAA"), the Fund is required to protect the privacy of your individually identifiable health information (referred to here as "protected health information" or "PHI"). Except as described in this Section 11, as provided for by federal, state or local law, or as you have otherwise authorized, the Plan only uses and discloses your PHI for the administration of the Plan and for processing claims. HIPAA permits the Fund to make certain types of uses and disclosures of PHI without requiring your written authorization for treatment, payment and health care operations purposes as described below:

> **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;
- When you are deceased;
- In an emergency situation;
- 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. Most uses or disclosures of psychotherapy notes (where applicable), uses and disclosures of PHI for marketing purposes and disclosures that constitute the sale of PHI require an authorization. Other uses and disclosures of your PHI other than those described above will be made only with your express written authorization. You may revoke your authorization by notifying the Fund in writing to the address in subsection C 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 member, 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, in limited circumstances 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.

B. Additional Rights Under HIPAA

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; (iv) the right to receive a paper copy of the Fund's Privacy Notice upon request; (v) the right to request restrictions on your PHI that the Plan uses or discloses about you to carry out treatment, payment or healthcare operations; and (vi) the right to request that the Plan communicate your PHI to you in confidence by alternative means or in an alternative location. You must write to the Fund's HIPAA Privacy Officer describing in detail the specific items requested, namely: (i), (ii) and/or (iii), above.

You have the right to, and will receive, notification if a breach of your unsecured PHI requiring notification occurs.

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, including your PHI that it created or received prior to the effective date of the change and your PHI it may receive in the future. If the Plan materially changes any of its privacy practices covered by this Notice, it will revise this Notice, and provide you with the revised Notice within 60 days of the revision (or within such other time frame required under the regulations). 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.

C. Contact Information

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 – United Parcel Service ("UPS") Retiree Health Fund
151 Northern Concourse
P.O. Box 4928
Syracuse, New York 13221-4928

D. Effective Date

This Notice is effective as of June 1, 2025, and will remain in effect unless and until the Fund publishes a revised Notice.

Section 12.
GENERAL INFORMATION AND ERISA RIGHTS

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 – United Parcel Service ("UPS") Retiree Health 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, three of whom are appointed by sponsoring labor unions and three of whom are appointed by employer Trustees of the New York State Teamsters Council Health and Hospital Fund. The Trustees employ an Executive Administrator and office staff to keep records and make certain benefit payments. Likewise, the Trustees employ certain administrators to process benefit claims under separate agreements.

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 – United Parcel Service ("UPS") Retiree Health 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 of the Trustees are:**

LABOR TRUSTEES

John Bulgaro, Co-Chairman

Mark May

Brian K. Hammond

George Harrigan

EMPLOYER TRUSTEES

Michael S. Scalzo, Sr., Co-Chairman

Chris Langan

Daniel W. Schmidt

Rusty Staab

5. **Source of Financing.** The New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund is funded by contributions made by UPS and by premiums paid by participants and from any income earned from investment of contributions. All moneys are used exclusively for providing benefits to eligible retired employees or their dependents, and the payment of all expenses incurred with respect to the operation of the Plan. The Trustees annually review the funding status of the Plan, and employ professional advisors, including investment managers, who are responsible for investment of Plan assets, and also including:

LEGAL COUNSEL

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

Cohen Weiss and Simon, LLP
909 Third Avenue
12th Floor
New York, New York 10022

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

Major Medical Benefits are self-funded and administered by:

Excellus BlueCross BlueShield, Central New York Region
333 Butternut Drive
Syracuse, New York 13214-1803

Prescription Drug Benefits are self-funded and administered by:

Effective January 1, 2022, the Fund utilizes the SaveOnSP program to help Participants save money on certain specialty medications. You can contact SaveOnSp at 1-800-683-1074 for more information or to enroll in the program.

Vision Benefits are insured by HM Life Insurance Company and administered by:

Davis Vision, Inc.
175 East Houston Street
San Antonio, TX 78205

Dental Benefits are self-funded and administered by:

Excellus BlueCross Blue Shield
Central NY Region
333 Butternut Drive
Syracuse, New York 13214
Telephone: 1-877-650-5840
Website: www.excellusbcbs.com

6. **Plan Year.** The Plan Year begins on January 1 and ends on December 31.

7. **Internal Revenue Service Employer Identification No.** 46-4111565

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.

10. 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.

11. **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.

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

Your Rights Under ERISA

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 Retiree Health 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.

Continue health care coverage for your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Your dependents may have to pay for such coverage. Review this booklet and the documents governing the Plan on the rules governing your family's right to COBRA Continuation Coverage.

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. Section 9 of 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 federal court, subject to the restrictions herein. 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, subject to the restrictions herein. 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, subject to the restrictions herein. Anyone bringing a legal action against the Fund or Trustees must bring and have the suit heard in the United States District Court for the Northern District of New York, and any legal action brought or initiated in any other venue must be transferred to the United States District Court for the Northern District of New York. 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.