New York State Teamsters Council Health & Hospital Fund

GENERAL ELIGIBILITY & ERISA RIGHTS INFORMATION

Effective June 1, 2025

Your Funds……Working For You

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GRANDFATHERED PLAN STATUS

The New York State Teamsters Council Health & Hospital Fund is a "Grandfathered Plan." This group health plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that our plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections of the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (315) 455-9790. You may also contact the Employee Benefit Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

IMPORTANT NOTES

1. For purposes of this booklet, the New York State Teamsters Council Health & Hospital 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 booklet provides information about the eligibility and coverage requirements, claims and appeals rights and procedures, protection of health information and ERISA rights related to your medical, hospital, prescription drug, dental, vision, legal, non-occupational disability, basic life insurance and accidental death and dismemberment benefits provided under the Fund. The specifics of the benefits provided are described in the accompanying booklets that address each benefit type separately.

3. Benefits are determined by the contribution rate paid to the Fund and the Benefit Selection Form signed by your employer and your local union. Receipt of an incorrect benefit booklet or Summary Plan Description does not entitle you or your dependents to benefits for which you are not eligible.

4. 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 the accompanying benefit-specific booklets, 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.

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 7 to this booklet.

6. The benefits described in this booklet and the accompanying benefits-specific booklets, may be provided as long as the parties to the Collective Bargaining Agreements continue to make contributions to the Fund that are sufficient to maintain the benefits.

7. 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.

8. In the event of any conflict between the language of the provisions contained herein and common provisions contained in benefit-specific booklets issued by the Fund, the language and provisions of this booklet will prevail.

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

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

Section 1

PARTICIPANT RESPONSIBILITIES

A. PLAN ADMINISTRATOR RESPONSIBILITIES

As detailed in Section 9 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 and the accompanying benefit-specific booklets, 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, 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 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;

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. Documentation of legal custody and responsibility for a grandchild or foster child for whom you have been declared legally responsible, if you wish to enroll your dependent grandchild or foster child;

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 marry or divorce;

2. You have a child, adopt a child, obtain legal custody or wish to cover a foster child, stepchild or grandchild of whom you have legal custody;

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 26; or

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

Section 3

ELIGIBILITY FOR FUND BENEFITS

A. ALL PARTICIPANTS - (Other than HOURLY CONSTRUCTION; PART TIME UPS; LOCAL 355; LOCAL 445; MONTHLY AND MUNICIPAL PARTICIPANTS)

Participant eligibility is determined by the Fund on a quarterly basis in accordance with the Fund's eligibility rules and the qualifying schedule detailed later in this Section. To be eligible for coverage, you must be credited with contributions for a minimum of thirty-six (36) days in a Qualifying Quarter and your employer must make the required contributions to the Fund on your behalf for such days.

Coverage will be effective on the first day of the Benefit Quarter which follows the Qualifying Quarter during which the above requirements were satisfied and will remain in effect for the three (3) months indicated unless terminated as a result of one of the events described in Subsection H of this Section. Subsequent quarters of eligibility will be earned based upon continued satisfaction of the thirty-six (36) day contribution minimum in the designated Qualifying Quarters.

Excess days of work credit do not carry over to the next quarter.

Qualifying Quarters	**Benefit Quarters**
September, October, November	January, February, March
December, January, February	April, May, June
March, April, May.	July, August, September
June, July, August.	October, November, December

A special rule applies to coverage for Major Dental Benefits. You must complete one year of continuous eligibility before you or your dependents become eligible for Major Dental Benefits. Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

Important Notes:

1. When an employee works four (4) or more days for one employer during a calendar week and the weekly rate is paid, the employee is credited with five (5) days towards the thirty-six (36) day eligibility requirement.

2. If active work ceases due to a strike or a plant closing, previously earned days of contributions will be recognized and credited for the purpose of determining eligibility for continued coverage.

B. HOURLY CONSTRUCTION PARTICIPANTS

Special eligibility rules apply. The eligibility of employees in the construction industry is based on hours of work for which the signatory employer makes the required contributions to the Fund.

Contributions paid at an hourly rate lower than that required by the Fund for the period of work will be "prorated" so that credited hours will be equal to the amount contributed divided by the required hourly contribution rate.

An employee in the construction industry earns eligibility for a Benefit Quarter provided the employer remits required contributions to the Fund for at least one hundred fifty **(150)** hours in a Qualifying Quarter. Hours in excess of the minimum amount required will be "rolled over" to maintain an employees' eligibility for benefit as follows:

Qualifying Quarters	**Benefit Quarters**
September, October, November	January, February, March
December, January, February	April, May, June
March, April, May	July, August, September
June, July, August.	October, November, December

- **300 Hours** in 2 Qualifying Quarters = Eligibility for **2 Benefit Quarters.**
- **450 Hours** in 3 Qualifying Quarters = Eligibility for **3 Benefit Quarters.**
- **600 Hours** in 4 Qualifying Quarters = Eligibility for **4 Benefit Quarters.**
- **750 Hours** in 5 Qualifying Quarters = Eligibility for **5 Benefit Quarters.**
- **900 Hours** in 6 Qualifying Quarters = Eligibility for **6 Benefit Quarters.**

    - **Where appropriate, the use of excess hours to continue eligibility will override standard termination provisions for Hourly Construction Participants.**

A special rule applies to coverage for Major Dental Benefits. You must complete one year of continuous eligibility before you or your dependents become eligible for Major Dental Benefits. Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

If you are retired and return to work for a Contributing Employer under the New York State Teamsters Conference Pension and Retirement Plan's critical shortage of workers employment exception, you will not be eligible to receive benefits under this Plan and no contributions will be remitted by your employer on your behalf.

C. PART TIME EMPLOYEES OF UNITED PARCEL SERVICE

Participant eligibility is determined by the Fund on a quarterly basis in accordance with the Fund's eligibility rules and the qualifying schedules that follow.

1. General Eligibility Rule for United Parcel Service Part-Time Employees

To be eligible for coverage, a part-time United Parcel Service employee must be credited with contributions for a minimum of two hundred ten **(210)** hours in a Qualifying Quarter and United Parcel Service must make the required contributions to the Fund on the employee's behalf for such hours. Coverage will be effective on the first day of the Benefit Quarter which follows and will remain in effect for the three **(3)** months indicated, unless terminated earlier as a result of one of the events described in Subsection H of this Section. Subsequent quarters of eligibility will be earned based upon continued satisfaction of the two hundred ten **(210)** hour contribution minimum in the designated Qualifying Quarters.

Excess hours of work credit do not carry over to the next quarter.

Qualifying Quarters	Benefit Quarters
September, October, November	January, February, March
December, January, February	April, May, June
March, April, May	July, August, September
June, July, August.	October, November, December

Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

This eligibility rule does not apply to United Parcel Service part-time Air Drivers, Air Walkers and Air Hub and Gateway employees that have a three (3) hour per day guarantee under Section 1, Section 2 and Section 3, respectively, of Article 40 of the National Master United Parcel Agreement. In addition, this eligibility rule does not apply to United Parcel Service part-time employees at the Stewart Airport in Newburgh, New York, and the Syracuse Airport in Syracuse, New York. This eligibility rule also does not apply to United Parcel Service part-time Cover Driver employees that have a two (2) day guarantee of eight (8) hours per day under Section 1 of Appendix A of the Upstate/West New York Districts Wage Schedule.

2. Special Eligibility Rules for Certain United Parcel Service Part-Time Employees

a. *Air Drivers, Air Walkers and Air Hub and Gateway*

To be eligible for coverage, part-time United Parcel Service employees that perform work under Section 1, Section 2 and Section 3, respectively, of Article 40 of the National Master United Parcel Agreement as Air Drivers, Air Walkers and Air Hub and Gateway employees and have a three hour (3) hour per day guarantee must be credited with contributions for a minimum of one hundred eighty **(180)** hours in a Qualifying Quarter and United Parcel Service must make the required contributions to the Fund on your behalf for such hours. Coverage will be effective on the first day of the Benefit Quarter which follows and will remain in effect for

the three **(3)** months indicated, unless terminated earlier as a result of one of the events described in Subsection Hof this Section. Subsequent quarters of eligibility will be earned based upon continued satisfaction of the one hundred eighty **(180)** hour contribution minimum in the designated Qualifying Quarters.

Excess hours of work credit do not carry over to the next quarter.

Qualifying Quarters	**Benefit Quarters**
September, October, November	January, February, March
December, January, February	April, May, June
March, April, May	July, August, September
June, July, August.	October, November, December

Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

b. *Stewart Airport – Newburgh, New York*
Syracuse Hancock International Airport – Syracuse, New York

To be eligible for coverage, part-time United Parcel Service employees that perform work at the Stewart Airport in Newburgh, New York, and Syracuse Hancock International Airport must be credited with contributions for a minimum of one hundred forty-four **(144)** hours in a Qualifying Quarter and United Parcel Service must make the required contributions to the Fund on your behalf for such hours. Coverage will be effective on the first day of the Benefit Quarter which follows and will remain in effect for the three **(3)** months indicated, unless terminated earlier as a result of one of the events described in Subsection H of this Section. Subsequent quarters of eligibility will be earned based upon continued satisfaction of the one hundred forty-four **(144)** hour contribution minimum in the designated Qualifying Quarters.

Excess hours of work credit do not carry over to the next quarter.

Qualifying Quarters	**Benefit Quarters**
September, October, November	January, February, March
December, January, February	April, May, June
March, April, May	July, August, September
June, July, August.	October, November, December

Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

c. *Cover Driver*

To be eligible for coverage, part-time United Parcel Service employees that perform work under Section 1 of Appendix A of the Upstate/West New York Districts Wage Schedule as Cover Drivers and have a two **(2)** day guarantee of eight **(8)** hours per day must be credited with contributions for a minimum of one hundred ninety-two **(192)** hours in a Qualifying

Quarter and United Parcel Service must make the required contributions to the Fund on your behalf for such hours. Coverage will be effective on the first day of the Benefit Quarter which follows and will remain in effect for the three **(3)** months indicated, unless terminated earlier as a result of one of the events described in Subsection H of this Section. Subsequent quarters of eligibility will be earned based upon continued satisfaction of the one hundred ninety-two **(192)** hour contribution minimum in the designated Qualifying Quarters.

Excess hours of work credit do not carry over to the next quarter.

Qualifying Quarters	**Benefit Quarters**
September, October, November	January, February, March
December, January, February	April, May, June
March, April, May	July, August, September
June, July, August.	October, November, December

Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

D. PARTICIPANTS OF LOCAL 355

Participant eligibility is determined by the Fund on a quarterly basis in accordance with the Fund's eligibility rules and the qualifying schedule that follows. To be eligible for coverage, you must be credited with contributions for a minimum of two hundred eighty-eight **(288)** hours in a Qualifying Quarter and your employer must make the required contributions to the Fund on your behalf for such hours. Coverage will be effective on the first day of the Benefit Quarter which follows and will remain in effect for the three **(3)** months indicated, unless terminated earlier as a result of one of the events described in Subsection H of this Section. Subsequent quarters of eligibility will be earned based upon continued satisfaction of the two hundred eighty-eight **(288)** hour contribution minimum in the designated Qualifying Quarters.

Excess hours of work credit do not carry over to the next quarter.

Qualifying Quarters	**Benefit Quarters**
September, October, November	January, February, March
December, January, February	April, May, June
March, April, May	July, August, September
June, July, August.	October, November, December

A special rule applies to coverage for Major Dental Benefits. You must complete one year of continuous eligibility before you or your dependents become eligible for Major Dental Benefits. Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

E. MONTHLY ELIGIBILITY

Participant eligibility is determined by the Fund on a **monthly basis** for certain participants. In such cases, the Employer must make the appropriate monthly contribution amount on the employee's behalf to the Fund prior to each month for the employee to be eligible for coverage.

Coverage will be effective on the first day of each month and will remain in effect for each month as long as the Employer is obligated to pay the required monthly contribution amount to the Fund each month.

An eligible employee that terminates employment would lose coverage at the end of the month last employed.

A special rule applies to coverage for Major Dental Benefits. You must complete one year of continuous eligibility before you or your dependents become eligible for Major Dental Benefits. Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

F. PARTICIPANTS OF LOCAL 445

Participant eligibility is determined by the Fund based upon eligibility rules established by your employer and set forth in the collective bargaining agreement. Eligibility may be determined on a quarterly basis (as described in A. above), on an hourly basis (as described in B. above) or on a monthly basis (as described in E. above). If you have any questions regarding the eligibility requirements that apply to you and your dependents, please contact the Fund Office.

A special rule applies to coverage for Major Dental Benefits. You must complete one year of continuous eligibility before you or your dependents become eligible for Major Dental Benefits. Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

G. ELIGIBILITY FOR EMPLOYEES OF NEW EMPLOYERS ENTERING THE FUND

Employees of new employers entering the Fund may attain immediate eligibility for all benefits except Major Dental benefits if the following conditions are satisfied and proof as required by the Fund Office is provided:

1. The employee must have worked for the new participating employer for at least thirty-six (36) days in the previous benefit quarter prior to the new employer entering the Fund; and

2. The employee must have been covered by an employer sponsored medical plan during the previous benefit quarter prior to the new employer entering the Fund.

The Fund will require the following documentation in making the determination if immediate eligibility is to be granted:

1. The new participating employer must provide payroll reports documenting the days worked during the previous benefit quarter for each employee; and

2. A copy of the most recent premium statement showing the employees who were enrolled, or a statement from the prior benefits administrator showing dates of the enrollment for the employers' employees during the previous benefit quarter for each employee.

Also, all eligible dependents of an eligible employee of a new employer will be granted immediate eligibility. **This will occur if the required enrollment form and documents described in Section 2.A are received by the Fund Office within ninety (90) days from the date that immediate eligibility is granted. If an employee is granted immediate coverage and terminates employment with the new contributing employer before working thirty-six (36) days in a succeeding eligibility quarter, coverage terminates on the date employment terminates.**

Employees of a new employer who do not meet the above requirements to gain immediate eligibility will become eligible for benefits in accordance with the current eligibility rules established by the Fund. This provision does not apply to construction and part time UPS employees

Notwithstanding the above, a special rule applies to coverage for Major Dental Benefits. You must complete one year of continuous eligibility before you or your dependents become eligible for Major Dental Benefits. Participants may opt out of the Dental Benefit at any time; if you would like to opt out, please contact the Fund Office for additional information.

H. TERMINATION OF ELIGIBILITY FOR FUND BENEFITS

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

1. The end of the Benefit Quarter which corresponds to the Qualifying Quarter in which you were last credited with thirty-six **(36)** days of contributions; or the required hours of contributions for Construction Participants or Part Time United Parcel Service Participants; or the required monthly contribution for monthly Employer Participants. If you take a leave of absence that is protected by the Family and Medical Leave Act of 1993 or New York Paid Family Leave and you would otherwise lose coverage during or after the leave period as a result of taking such leave, contributions by your employer and eligibility for benefits will continue during the leave periods, provided your employer makes the required contributions to the Fund; or

2. The end of the Benefit Quarter which corresponds to the Qualifying Quarter or the month in which you receive the maximum Weekly Accident and Sickness Benefits from the Fund and you do not return to work with a participating employer; or

3. For your dependents, the date your eligibility as an employee terminates or the date each dependent no longer qualifies as an eligible dependent specifically:

    a. For all dependents in the event of your death, at the end of the last Benefit Quarter based on earned eligibility.

b. For your husband or wife, the date of a divorce or judicial order of legal separation.

c. For your children, (including your biological child, step-child, adopted child, child placed for adoption, or foster child, including a grandchild who has been placed with you by a court of competent jurisdiction) upon attainment of age 26.

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

I. DEPENDENT ELIGIBILITY

You, as the employee, are covered if you meet the current eligibility requirements as established by the Fund and your employer meets all Fund rules and regulations for participation. The following dependents who meet the Fund's eligibility requirements are also covered:

1. **Your legal spouse.** Your legal spouse. 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 eligible** if your spouse is employed and your spouse's employer offers your spouse single or family coverage under that employer's group health plan with no premium cost.

   This means that your spouse cannot "opt out" of such no cost coverage provided by his or her employer, or decline such coverage due to a buyout or monetary payment from his or her employer not to enroll, and still be eligible for coverage through the Fund.

   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 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 6 for primary coverage information.

2. **Eligible Children.** Children (including biological children, adopted children, children placed for adoption, stepchildren, foster children, including a grandchild who has been placed in your custody by a court of competent jurisdiction, or other minor child of a family member for whom you have court awarded full custody) are eligible for the Plan's coverage until attainment of age 26.

   Children named in a Qualified Medical Child Support Order which meets the requirements of ERISA as described below, are also eligible dependents for purposes of the Plan's coverage. Permanently and totally disabled children of the Participant will

continue to be covered past age 26 for as long as they remain permanently and totally disabled as described below.

Your eligible children also include your stepchildren who meet the specified age restrictions. However, the Plan's obligation to provide benefits will be secondary to any obligation of either or both of the natural parents created by court order or judgment of divorce or of legal separation. The stepparent will promptly provide a copy of any such court order or judgment and, in the event there is imposed such obligation on the natural parent or parents, the stepchildren will first seek payment or provision of benefits pursuant to said obligation of the natural parent(s). If collection under, or enforcement of, the natural parent's obligation is impossible or impracticable, the Plan will provide benefits the same as for legally adopted children according to the terms and conditions of the Plan. The Fund will be assigned the right to enforce such obligation so as to obtain reimbursement from the responsible natural parent or parents, or from their insurer, for benefits provided.

Foster children include children who meet the specified age restrictions and are placed with the Participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

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

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

For purposes of the Dependent Life Insurance Benefit, your child must be more than 30 days old, must not be married, and must be your legal dependent for federal income tax purposes.

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 QMCSOs.

Upon receipt of a Medical Child Support Order ("Support Order"), the Plan Administrator will promptly notify the participant and each child of receipt of the Support Order. The Participant and

each child will be notified within a reasonable period of time whether the Support 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 Support Order is a QMCSO, 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 a Support 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.

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.

J. SPECIAL ELIGIBILITY PROVISIONS

1. **All Participants (Other than Municipal Participants)**. The eligibility rules of the Fund require that all eligible employees covered for benefits through the Fund must enroll for benefits and also must enroll for benefits based on marital/family status. Thus, married employees must enroll for two-person coverage; married employees with a child or children must enroll for family coverage; a single employee must enroll for individual coverage.

2. Municipal Participants**.**

a. Current employees of a new Municipal Employer entering the Fund can "opt out" of the Fund's coverage prior to the effective date of their Municipal Employer's participation with the Fund if they are covered by another health plan. The employee must complete the required forms showing the Fund that they are covered by another health plan. The employee will not be allowed to later enroll in the Fund's Plan unless the other coverage is lost by reasons beyond the control of the employee.

Thereafter, all newly hired full time and part time employees of the Municipal Employer will be required to enroll for benefits and will not be provided the opportunity to "opt out".

b. Municipal employees can elect to take single coverage even if they are married or have children and provide proof of dependent coverage elsewhere.

K. SPECIAL ENROLLMENT RIGHTS

Coverage under this Plan is automatic upon your eligibility. However, if you decline enrollment for yourself or any of your eligible dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 90 days after the marriage, birth, adoption or placement for adoption.

You and your dependents may also enroll in this Plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in this Plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

It is important to notify the Fund Office immediately of any change in your family status due to marriage, birth of a child, death, divorce or judicial order of legal separation or any change of address.

L. FAMILY AND MEDICAL LEAVE

Under the Family and Medical Leave Act (FMLA), you may qualify for benefits during a period you are on leave for the purposes described in the Act. However, to be eligible for such a leave, your employer must have been obligated to make contributions to the Fund on your behalf for at least 1,250 hours in the preceding twelve (12) month period. You must also have worked for that employer for at least twelve (12) months immediately preceding the date your leave will commence.

Not all employers are covered by the Act. Only employers which have at least fifty (50) employees on each working day during each of twenty (20) weeks in the current or preceding calendar year are affected. In addition, you must:

1. Work at a location where the employer has at least 50 employees; or

2. Work within 75 miles of one or more work sites where the employer has 50 or more employees to be entitled to leave under the Act.

Your employer must notify the Fund that you are on leave for one of the purposes described in the Act, continue to include you on its monthly remittance report to the Fund, and continue to make monthly contributions for you. The amount of those monthly contributions will be based on:

1. The average number of hours you worked during the preceding three (3) calendar months; and

2. The hourly rate at which the employer contributes for active employees.

While you are on leave, you (and your eligible dependents, if any) will receive the same benefits you were entitled to receive immediately before the leave began.

Your eligibility for the continuation of benefits under the Family and Medical Leave Act will be terminated upon the occurrence of one of the following events:

1. Your employer fails for any reason to make the required contributions to the Fund on your behalf while you are on leave; or

2. You exhaust the twelve (12) weeks of annual family medical leave which you are entitled to under Federal Law; or

3. Your employer notifies the Fund that you do not intend to return to the employer's employment.

In the event your employer stops making contributions for you for any reason, the Fund will continue to pay your benefits (and those of your dependents, if any) until one of the events occurs as described in Section H – "Termination of Eligibility for Fund Benefits" or Section 4(B) – "When Coverage Terminates".

M. NEW YORK PAID FAMILY LEAVE

Effective January 1, 2018, New York State Paid Family Leave ("PFL") insurance coverage will be provided by the Health and Hospital Fund pursuant to an insurance policy with Union Labor Life ("Ullico").

Your PFL coverage under Ullico's policy is dependent on your employer remitting the necessary premiums on a timely basis to the Fund Office, and you meeting any applicable eligibility requirements under the policy. The premiums for PFL coverage may be funded entirely by employee payroll deductions.

PFL provides paid time away from work for the following reasons:

- To ***bond*** with a newly born, adopted, or fostered child.
- To ***care*** for an eligible family member with a serious health condition.
- To ***assist*** family members when someone is deployed abroad on active military service.

In general, full-time employees are eligible for coverage after 26 weeks of consecutive employment and part-time employees are eligible after 175 days worked within a consecutive 52-consecutive period.

Subject to the terms of the insurance policy and New York State law, the benefit amounts are as follows:

Effective Date	Benefit Amount	Duration of Benefits
January 1, 2020	60% of the employee's average weekly wage not to exceed 60% of the state average weekly wage. The maximum weekly benefit for 2020 is $840.70.	Up to 10 Weeks
January 1, 2021	67% of the employee's average weekly wage not to exceed 67% of the state average weekly wage	Up to 12 Weeks

The PFL coverage will be administered by Ullico. To file a claim for PFL benefits, you must contact the Fund Office or Ullico:

The Union Labor Life Insurance Company
Claim Service Center
P.O. Box 49 Bloomfield, CT 06002
Toll Free: 1-888-855-4261
Fax: 1-860-769-6986
8:00 am to 4:00 p.m. Eastern Standard time
(Monday through Friday)

The completed claim forms must be submitted to Ullico.

A participant that is eligible and enrolled in this Plans' health coverage immediately prior to New York Paid Family Leave being taken may continue to qualify for such coverage so long as the participant is otherwise eligible and the employer continues to remit the required contributions on his or her behalf to this Plan.

N. MILITARY SERVICE

When a participant leaves employment for full-time military service, as defined by Federal Law, the participant and his eligible dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under Federal Law. This coverage lasts for up to twenty-four (24) months beginning on the date of the Participant's absence from employment. However, the coverage will terminate before the end of the twenty-four (24) month period if the Participant entering military service fails to pay the monthly premiums or is discharged before the end of the twenty-four (24) month period and fails to make a timely application for reemployment.

To elect Military Service continuation coverage, contact the Fund Office as soon as you are notified of your military obligation to obtain the necessary enrollment information for you and your dependents.

O. PREMIUM ASSISTANCE PROGRAM

The Fund provides a Premium Assistance Program for eligible retirees. The eligibility requirements and details of this program are described in Appendix A attached to this booklet.

Section 4

COVERAGE FOR BENEFITS

A. WHO IS COVERED

Coverage starts on the day the Fund determines you or your spouse have met the eligibility requirements as defined previously. However, there are special rules for the coverage of eligible dependent children as described below.

1. An eligible dependent child is covered, except for a newborn child, at the earliest of the following dates:

    a. A court of law places the dependent with you for adoption by accepting a consent to adopt, and you enter into an agreement to support the dependent; or

    b. The date a court of law makes you or your spouse legally responsible for the support and maintenance of the dependent in accordance with a Qualified Medical Child Support Order; or

    c. The date that a child of the Participant (as defined in Section 3, above) who is under the age of 26 enrolls in coverage under the Plan.

2. Your newborn child is covered at birth for all benefits except dependent life coverage, which begins after thirty **(30)** days.

3. A child you intend to adopt will be covered from the moment of birth or when placed with you if:

    a. You take physical custody of the child upon discharge from the hospital or birthing center; and

    b. Within thirty **(30)** days of the child's birth you file a petition to adopt or file for temporary legal guardianship under New York State Domestic Relations Law or comparable law of the state where you reside.

If one of the child's biological parents has coverage for the child's initial hospital stay, or a notice or revocation of adoption has been filed, or one of the biological parents revokes consent to the adoption, no coverage will be provided by the Fund for the child.

Please Note: You are responsible for providing the Fund Office with the required birth certificates, marriage certificates, divorce decrees, adoption decrees, or any other documentation the Fund may require. This information must be received by the Fund within ninety **(90)** days of the date 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 day of the month in which the information is finally received.

B. WHEN COVERAGE TERMINATES

Coverage for you and your dependents will cease on the earliest of the following dates even if the number of days credited to you in the most recent Qualifying Quarter would otherwise continue your coverage:

1. If your Collective Bargaining Agreement and/or Fund Participation Agreement expires and your employer has not signed an Interim Agreement for continued contributions pending execution of a new Collective Bargaining Agreement, the date your coverage ceases is the date the operative Collective Bargaining Agreement or Participation Agreement expires.

2. If your Collective Bargaining Agreement and/or Fund Participation Agreement expires and if your employer has signed an Interim Agreement for continued contributions pending execution of a new Collective Bargaining Agreement, the date your coverage ceases is the date stated in the Fund's notice to your employer that coverage is terminated in accordance with that Interim Agreement.

3. If the employees of a participating employer vote to decertify a Local Teamster Union as their bargaining agent, then the date that your coverage ceases is the date on which the decertification vote occurred.

4. The date the Fund determines contributions to the Fund will no longer be paid from your employer due to a voluntary decision by the employer or its employees to cease participation in the Fund, even if the number of days credited to you in the most recent Qualifying Quarter would serve to continue your coverage.

5. Whenever the Fund determines that, for any reason, your employer has failed to remit current and complete contributions on behalf of all covered employees or is in breach of any Fund rules.

In the above described situations, employees and dependents would not normally have sustained a qualifying event to trigger COBRA continuation.

Section 5

COBRA CONTINUATION COVERAGE

This Section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This right only applies to medical, prescription drug, dental, and vision coverage and does not apply to legal benefits, life insurance, accidental death and dismemberment, or disability coverage. This Section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

A. RIGHT TO COBRA CONTINUATION COVERAGE

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office.

COBRA continuation coverage is a continuation of Plan health 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, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

1. <u>Qualified Beneficiaries</u>

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

a. your hours of employment are reduced; or
b. your employment ends for any reason other than your gross misconduct.

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

a. your spouse-employee dies;
b. your spouse-employee's hours of employment are reduced;
c. your spouse-employee's employment ends for any reason other than his or her gross misconduct;
d. your spouse-employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or

e. you become divorced from your spouse.

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

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

2. **Qualifying Events**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Fund Office of the qualifying event. As described below, you must notify the Fund Office of any other qualifying events.

3. **Eligibility Notification**

For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), **you must notify the Fund Office in writing within sixty (60) days after the qualifying event occurs.** You must provide written notice to: New York State Teamsters Council Health and Hospital Fund, P.O. Box 4928, Syracuse, NY 13221-4928. Failure to notify the Fund Office of the qualifying event within the time limits may result in your loss of eligibility for COBRA continuation coverage.

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. In general, the Fund Office 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.

4. **Election Period**

Each individual will have 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Fund Office that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. You will not have another opportunity to elect continuation

coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA Election Form, if mailed, is postmarked no later than the due date. If the election is hand-delivered, the date of delivery must be on or before the due date. If you change your mind after first rejecting COBRA continuation coverage but before the end of the 60 day election period, your COBRA continuation coverage will begin on the date the completed Election Form, if mailed, is post-marked. If the Election Form is hand-delivered, your COBRA continuation coverage will begin on the date of delivery.

5. **Consequences of Failing to Elect COBRA Continuation Coverage**

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

B. LENGTH OF COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of thirty-six **(36)** months. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen **(18)** months. If, while you are receiving COBRA continuation coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change.

There are three ways in which this eighteen **(18)** month period of COBRA continuation coverage can be extended:

1. **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven **(11)** months of COBRA continuation coverage, for a total maximum of twenty-nine **(29)** months. To be eligible, the qualifying event has to be a reduction in hours or termination of employment other than for gross misconduct. In addition, the disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the eighteen **(18)** month period of continuation coverage. **You must notify the Fund Office of the disability in writing within sixty (60) days of the Social Security Administration determination and before the expiration of the eighteen (18) month period of continuation coverage. This notice must be sent to:**

2. **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving eighteen **(18)** or **(29)** months of COBRA continuation coverage due to a reduction of hours or termination of employment for reasons other than gross misconduct, the spouse and dependent children in your family can get up to eighteen **(18)** additional months of COBRA continuation coverage, for a maximum of thirty-six **(36)** months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **This notice must be provided to the Fund Office in writing within sixty (60) days from the date of the second qualifying event.**

3. **Third qualifying event extension of 18-month period of continuation coverage**

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen **(18)** months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six **(36)** months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight **(8)** months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to thirty-six **(36)** months after the date of Medicare entitlement, which is equal to twenty-eight **(28)** months after the date of the qualifying event (thirty-six **(36)** months minus eight **(8)** months).

4. **Termination of COBRA Continuation Coverage**

COBRA continuation coverage will end at an earlier time for any of the following reasons:

a. The employer no longer participates in the Fund, and, through another health plan, provides health coverage to the class of the employer's employees formerly covered under the Fund. If this occurs, your COBRA coverage will end and you should receive COBRA coverage through your employer's new health plan.

b. Failure to pay the monthly premium on time.

c. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions ***(note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act)***.

d. The individual becomes entitled to benefits under Part A or Part B of Medicare.

e. If the individual is on a COBRA disability extension and there is a final determination that the individual is no longer disabled, COBRA coverage may be terminated for the individual and his/her dependents.

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

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

C. COST OF COBRA CONTINUATION COVERAGE

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The monthly premium will be based on the average cost which the Plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Plan. The monthly COBRA premium will usually be more than the monthly premium charged to self-pay participants.

D. IF YOU HAVE ANY QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office using the contact information shown below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

E. KEEP THE FUND OFFICE INFORMED OF 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.

F. ALTERNATIVE TO COBRA COVERAGE

As an alternative to purchasing COBRA through this Plan, you may purchase health coverage through the exchange Marketplace. The Marketplace is designed to help people without employer-sponsored coverage find health insurance that meets their needs and fits their budget. More information about the Health Insurance Marketplace generally is available at: www.HealthCare.gov. In comparing coverage through the Marketplace to COBRA coverage, you should consider whether you would be eligible for a tax credit that lowers your monthly premiums right away. Being eligible for COBRA does not limit your eligibility for coverage or for a tax credit through the Marketplace. If you would like more

information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence. In New York State, the website for the Marketplace is: www.NYStateofHealth.ny.gov.

G. CONTACT INFORMATION

New York State Teamsters Council Health and Hospital Fund
P.O. Box 4928 Syracuse, NY 13221-4928
Phone: 315.455.9790 Fax: 315.455.1237
Toll Free: 877.698.3863

Section 6

PROVISIONS WHICH AFFECT 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. HMOs 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.);

    g. Medicare; or

    h. 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. If an individual is covered under the Plan as an employee or member that is other than as a dependent, the Plan is primary, except that:

(1) If the individual is also eligible for and/or in enrolled in Medicare, and, if the rules established by the Social Security Act of 1965, as amended, also known as the Medicare Secondary Payor Rules, make Medicare primary to the Plan. However, the general rule is that the Plan is primary to Medicare for active employees who are eligible for and/or enrolled in Medicare.

If the rules established by the Social Security Act of 1965, as amended, also known as the Medicare Secondary Payor Rules, make Medicare secondary to the program covering the individual as a dependent of a person in current employment status (defined as an employee, employer, or person associated with an employer in a business relationship) with respect to the employer maintaining the program, then the following rules apply:

i the Plan, as the program covering the individual as a dependent of a person in current employment status, pays first,

ii Medicare pays second,

iii the program covering the retired individual as an employee or member pays third.

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, I (Dependent Eligibility) 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, I (Dependent Eligibility) 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,

I (Dependent Eligibility) 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.

(5) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the plan that covered the person for the longer period of time is the primary plan, and the plan that covered the person for the shorter period of time is the secondary plan.

(6) In the event that a dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph c. 1-3 to the dependent child's parent(s) and spouse.

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 8 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; and

   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 Section 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 <u>any</u> 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 ensure 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 attorneys 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 7

CLAIMS AND APPEAL PROCEDURES

A. INITIAL DECISIONS AND ADVERSE BENEFIT DETERMINATIONS

The "initial decision" is the first notice you will receive from the Fund or its applicable claims administrator 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 and Dental Benefits (Administered by Excellus BlueCross BlueShield of Central New York) 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 and Dental Benefits administered by Excellus BlueCross BlueShield of Central New York 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 of Central New York 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 BlueShield of Central New York, Prescription Drug Benefits administered by Express Scripts, Inc. and Dental Benefits administered by Lifetime Benefit Solutions, Inc.

For Urgent Care Claims, you will be notified by the third-party administrator(s) 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 BlueShield of Central New York (the third-party administrator for Medical and 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 and Dental Benefits administered by Excellus BlueCross BlueShield of Central New York.

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 BlueShield of Central New York 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 747000
Cincinnati, OH 45274-7000

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.

Non-Occupational Weekly Disability Benefits (Administered by Union Labor Life Insurance Company)

The Non-Occupational Weekly Disability Benefits and New York Paid Family Leave Benefits are administered by Union Labor Life Insurance Company ("Ullico"). If your claim for Non-Occupational Weekly Disability Benefits or New York Paid Family Leave Benefits is denied in whole or in part for any reason, then within 45 days after Ullico receives your claim, Ullico will send you written notice of

its decision. This period may be extended for up to two 30-day periods due to matters beyond the control of the insurer. For any extensions, Ullico will provide advance written notice indicating the circumstances requiring the extension and the date by which it expects to render a decision. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues (if any), and you shall be afforded at least 45 days within which to provide specified information (if applicable). A decision will then be made within 30 days after the earlier of the date you supply the requested information or the date by which you must supply the additional information.

Basic Life Insurance and Accidental Death and Dismemberment Insurance Benefits (Administered by The Standard Life Insurance Company of New York)

The Basic Life Insurance and Accidental Death and Dismemberment Insurance Benefits are administered by The Standard Life Insurance Company of New York ("Standard")

A. If your claim based on death or a covered loss not based on disability is denied in whole or in part for any reason, then within 90 days after Standard receives your claim, Standard will send you written notice of its decision, unless special circumstances require an extension, in which case Standard will send you written notice of the decision no later than 180 days from the date it receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the benefit determination.

B. If your claim based on your disability is denied in whole or in part for any reason, then within 45 days after Standard receives your claim, Standard will send you written notice of its decision. This period may be extended for up to two 30-day periods due to matters beyond the control of the insurer. For any extensions, Standard will provide advance written notice indicating the circumstances requiring the extension and the date by which it expects to render a decision. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues (if any), and you shall be afforded at least 45 days within which to provide specified information (if applicable). A decision will then be made within 30 days after the earlier of the date you supply the requested information or the date by which you must supply the additional information.

Dependent Life Insurance Benefits (Administered by the Board of Trustees of the New York State Teamsters Council Health and Hospital Fund)

The Dependent Life Insurance Benefits are administered by the Fund. If your claim for Dependent Life Insurance is denied in whole or in part for any reason, then within 90 days after the Fund receives your claim, the Fund will send you written notice of its decision, unless special circumstances require an extension, in which case the Fund will send you written notice of the decision no later than 180 days from the date it receives your claim. If an extension is necessary, you will be given written notice of

the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the benefit determination.

Legal Benefits (Administered by Moyer & Associates)

The Legal Benefits are administered by Moyer & Associates. If you believe you are eligible for benefits, a representative from Moyer & Associates will contact the Fund on your behalf to verify the status of your eligibility. If the Fund advises that you are not eligible, Moyer & Associates will notify you of this determination immediately. If you are denied coverage by Moyer & Associates, or by any Participating Attorney, you may file a claim requesting benefits by writing to Moyer & Associates at the following address:

Moyer & Associates
28 East Main Street, Suite 1200
Rochester, NY 14614

Moyer & Associates will make a determination on your claim within 7 days from receipt of your letter.

C. NOTICE OF ADVERSE BENEFIT DETERMINATION

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 or disability benefits, 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 or disability 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 administrators) 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 BlueShield of Central New York 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 BlueShield of Central New York, with respect to Concurrent Medical Benefit Claims and 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 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.

Legal Benefit Claims:

To appeal an adverse determination of a Legal Benefit, you must contact the Fund Office in writing stating your desire to appeal the determination. You have 60 days to appeal such a claim.

Non-Occupational Weekly Disability Benefit and New York Paid Family Leave Benefit Claims:

To appeal an adverse determination of a Non-Occupational Weekly Disability Benefit, you must contact Ullico in writing stating your desire to appeal the determination. You have 180 days to appeal such a claim.

Basic Life Insurance and Accidental Death and Dismemberment Benefits:

To appeal a Basic Life Insurance or Accidental Death and Dismemberment Insurance adverse benefit determination, you must contact Standard in writing stating your desire to appeal the determination. Your correspondence should be directed to Standard.

A. You have 60 days to appeal an adverse benefit determination based on death or a covered loss not based on disability.

B. You have 180 days to appeal an adverse benefit determination based on your disability.

Dependent Life Insurance Benefits:

To appeal a Dependent Life Insurance adverse benefit determination, you must contact the Fund Office in writing stating your desire to appeal the determination. You have 60 days to appeal such a claim.

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 other than those involving the Basic Life Insurance and Accidental Death 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 BlueShield of Central New York, Lifetime Benefit Solutions, Inc., 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 of Central New York 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.

Basic Life Insurance and Accidental Death and Dismemberment Insurance Benefit Claims:

A. Appeals of adverse Basic Life Insurance and Accidental Death and Dismemberment Benefit Insurance determinations based on death or a covered loss not based on disability must be determined by the insurance company within 60 days. The 60 day period may be extended by up to 60 additional days if there are special circumstances that require an extension of time for processing the claim. If an extension is necessary, the insurance company will provide you with notice that indicates the special circumstances that require an extension of time and the date by which the Plan expects to render its determination on review.

B. Appeals of adverse determinations based on your disability must be decided by the insurance company within 45 days. The 45-day period may be extended by up to 45 additional days if there are special circumstances that require an extension of time for processing the claim. If an extension is necessary, the insurance company will provide you with notice that indicates the special circumstances that require an extension of time and the date by which the Plan expects to render its determination on review.

Non-Occupational Weekly Disability Benefits and New York Paid Family Leave Benefits: Appeals of adverse Non-Occupational Weekly Disability Benefit and New York Paid Family Leave Benefit claims must be decided by the insurance company within 45 days. The 45 day period may be extended by up to 45 additional days if there are special circumstances that require an extension of time for processing the claim. If an extension in necessary, the insurance company will provide you with notice that indicates the special circumstances that require an extension of time and the date by which the Plan expects to render its determination on review.

All Other Claims (Including Dependent Life Insurance Benefit and Legal Benefit Claims): The Trustees at their next regularly scheduled meeting will make a determination of appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Plan will notify you of the benefit determination not later than 5 days after the determination is made.

The following applies to any benefit determination conditioned on a finding of disability by the Plan. These rules do not apply to a determination conditioned on a finding of disability by a party other than the Plan (e.g. the Social Security Administration).

1. Adverse benefit determination notices will include the following:

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

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

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

        (3) 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 ON 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 the Fund's Medical Benefits SPD booklet section titled 'Protection from Surprise Bills.'

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

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

Coverage Determinations Subject to External Review

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

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

Requesting an External Review

If you meet the conditions described above, you or your authorized representative may request an external review by completing and filing the required form with the Plan. The Plan will send the external review application to you with the notice of final adverse determination. You or your authorized representative will have the opportunity to submit additional information on the requested

service; and you may be required to authorize the release of any medical records needed to reach a decision on the external review. **You must file your request for an external review with the claims administrator within four months after receiving a final adverse determination.**

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

Effect of External Review Determination

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

Questions

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

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 or the date stated in the letter upholding the adverse benefit determination. 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. For additional information regarding your right to seek judicial review, see "*ERISA Rights*" in Section 9, "*General Information and ERISA Rights*", below.

H. DEFINITIONS

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

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.

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 (also as a Proof of Loss under the Basic Life Insurance and Accidental Death and Dismemberment Insurance Group Policy issued by the Standard Life Insurance Company of New York). 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.

Authorized Representative – An 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 8

HIPAA: HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

A. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and amendments made by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") the Fund is required to protect the privacy of your individually identifiable health information (referred to here as "protected health information" or "PHI"). HIPAA permits the Fund to make certain types of uses and disclosures of PHI for treatment, payment and health care operations purposes:

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

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

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

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

- As required by law;
- For public health activities;
- To report victims of abuse, neglect or domestic violence;
- For health oversight activities;
- For judicial and administrative proceedings;
- For law enforcement purposes and to report a crime;
- To permit authorized organ donations;
- For valid research purposes;
- To avert a serious threat to health or safety; and

- For a specialized government function involving the military and veterans activities, national security, protective services for the President, correctional facilities, law enforcement custodial situations, and government programs providing public benefits.

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

Other uses and disclosures will be made only with your written authorization. You may revoke your authorization by notifying the Fund in writing to the address below in Section C. 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, 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; and (iv) the right to receive a paper copy of the Fund's Privacy Notice upon request. You must write to the Fund's HIPAA Privacy Officer describing in detail the specific items requested, namely: (i), (ii) and/or (iii), above.

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

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

C. CONTACTING THE FUND

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

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

Section 9

GENERAL INFORMATION AND ERISA RIGHTS

General Information

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

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

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

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

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

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

The names of the Trustees are:

LABOR TRUSTEES

John A. Bulgaro, Co-Chairman	**Mark D. 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.** Payments are made to the New York State Teamsters Council Health & Hospital Fund by individual employers under Collective Bargaining Agreement provisions, by some employees through self-payments and from any income earned from investment of contributions. All moneys are used exclusively for providing benefits to eligible employees or their dependents, and the payment of all expenses incurred with respect to the operation of the Plan. The Trustees 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, DC 20004

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

Paravati, Karl, Green and De Bella, LLP

Landmarc Building
520 Seneca St, Suite 105
Utica, NY 13502

AUDITOR

D'Arcangelo & Company
120 Lomond Court
Utica, NY 13502

INVESTMENT ADVISOR

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

ACTUARY/CONSULTANT

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

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

Hospital, Medical/Surgical and Supplemental Medical Benefits are self-funded and administered by:

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

Prescription Drug Benefits are self-funded and administered by:

Express Scripts, Inc.
P.O. Box 747000
Cincinnati, OH 45274-7000

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

Davis Vision, Inc.
159 Express Street
Plainview, NY 11803

Dental Benefits are self-funded and administered by:

Excellus BlueCross BlueShield
333 Butternut Drive
Syracuse, NY 13214-1803

Dependent Death Benefits are self-funded and administered by:

The New York State Teamsters Council Health and Hospital Fund
P.O. Box 4928
Syracuse, NY 13221-4928

Life Insurance and Accidental Death & Dismemberment Benefits are insured and provided by:

The Standard Life Insurance Company of New York
333 Westchester Avenue, West Building, Suite 300
White Plains, NY 10604

Weekly Disability Benefits and New York Paid Family Leave Benefits are insured and provided by:

Union Labor Life Insurance Company
8403 Colesville Road
Silver Spring, MD 20910

Legal Benefits are insured and administered by:

Moyer & Russi, P.C.
28 East Main Street, Suite 1200
Rochester, NY 14614

Health Reimbursement Account Benefits are administered by:

Lifetime Benefit Solutions, Inc.
P.O. Box 21146
Eagan, MN 55121
1-800-327-7130

www.LifeTimeBenefitSolutions.com

See the "Health Reimbursement Account Plan" for more information on specific eligibility criteria for this program.

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

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

8. **Plan Number.** 501

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

The Trustees reserve the right to amend the eligibility rules at the time of termination. In any case, the Trustees shall use any remaining assets of the Plan to provide benefits and pay administration expenses or otherwise carry out the purpose of the Plan in an equitable manner until all assets have been disbursed.

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

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

ERISA Rights

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

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

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

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

3. **Receive a summary** of the Plan's Annual Financial Report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

In addition to creating rights for plan participants, ERISA imposes duties upon people who are responsible for the operation of the Plan. The people who operate your Plan are called "fiduciaries" and have a duty to operate the Plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Section 7 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. See "Jurisdiction and Venue" below. 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. See "Jurisdiction and Venue" below. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that the Plan fiduciaries have misused the Plan's money or that you have been discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Jurisdiction and venue: Jurisdiction and venue for any claims against the Fund or Trustees are proper only in the U.S. District Court for the Northern District of New York. Anyone bringing a legal action against the Fund or the Trustees must bring and have the suit heard in that court. 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.

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.

Section 10

PREMIUM ASSISTANCE PROGRAM

This section describes the Premium Assistance Program offered by the New York State Teamsters Council Health & Hospital Fund. The Premium Assistance Program provides a benefit to eligible individuals to subsidize the cost of retiree health care. All matters regarding this benefit are described in the attached "Appendix A".

APPENDIX A

Premium Assistance Program

HEALTH CARE REFORM

You should note that this Premium Assistance Program ("Program") is a "retiree-only" plan. This means that the coverage offered under this Program 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 Program 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 Program. If you would like more information about the Marketplace you should visit www.healthcare.gov.

ELIGIBILITY AND COVERAGE FOR BENEFITS

A. INITIAL ELIGIBILITY AND COVERAGE

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

- Be less than age 65 and not eligible for Medicare; and
- Have a minimum of 60 quarters of participation in the Health Fund, or 40 quarters of participation in the Health Fund, if retiring with a Disability Pension; and
- Have not incurred a 3-year Break-in-Service from the Pension Fund at the time of retirement with an Early, Disability, Regular, or Thirty-Year Pension; and
- Enroll in an approved medical plan for retirees designated by the Health Fund or a Teamster Affiliated Local Union.

If a retiree who satisfies the first three conditions described above at the time of retirement is eligible for other medical benefits, such as through an employer sponsored health plan or as the dependent of a working spouse, the retiree can elect to postpone participation in the Premium Assistance Program

until the first day of the month following termination of such other coverage. (Condition 4 described above must also be satisfied at the time of enrollment).

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

B. MONTHLY SUPPLEMENT AND PREMIUM PAYMENT

If you meet the eligibility requirements set forth in Section A above, you will be entitled to receive a monthly supplement of $200 toward your premiums for retiree health insurance.

You will be entitled to receive a larger supplement if you work beyond your Unreduced Retirement Date (as defined in the New York State Teamsters Conference Pension and Retirement Fund Summary Plan Description), as follows:

Additional Year Worked After Unreduced Retirement Date	Additional Premium Assistance Earned in that Year	Total Premium Assistance Including Initial $200 Supplement
1st Year	$50 per month	$250 per month
2nd Year	$50 per month	$300 per month
3rd Year	$50 per month	$350 per month
4th Year	$50 per month	$400 per month
5th Year	$100 per month	$500 per month

Regardless of how long you defer your retirement beyond your Unreduced Retirement Date, the maximum monthly premium assistance amount you can earn is $500 (including the initial $200 supplement).

You must defer retirement throughout the entire year (full 12 months) to earn the full additional amount for that year. If you defer retirement less than 12 months during a year, you will earn a prorated share (based on the number of fully completed months deferred) of the additional premium amount for that year.

For example, if your Unreduced Retirement Date is January 1, 2015 and you defer retirement until January 1, 2017, you will have deferred retirement for 2 full years and will have earned total premium assistance equal to $300 ($100 plus the $200 already provided).

If, instead, you only defer retirement until October 1, 2016, you would earn $50 for the 1st year in addition to the $200 already provided, plus $37.50 for the 2nd year (representing the maximum of $50 multiplied by 9 months deferred/12 months). As a result, you will have deferred retirement for a total of 21 months and have earned premium assistance equal to $287.50.

C. TERMINATION OF ELIGIBILITY AND COVERAGE FOR FUND BENEFITS

Eligibility for Fund Benefits will cease on the **earliest** of: (1) when the Plan ends; (2) upon your death; (3) after 10 years (120 months) of coverage or your attainment of age 65, whichever comes first; or (4) when you become eligible for Medicare.

D. ENROLLMENT PROCESS

Participation in the Premium Assistance Program is not automatic. You need to enroll. It is your responsibility to:

- If electing a retiree health plan through the Health Fund, obtain, complete and return to the Fund Office enrollment documents which include: Excellus Blue Cross/Blue Shield enrollment applications and the Pension Deduction Authorization for Retiree Health Fund Programs, reflecting:
  - **Your election of one of the Plans set forth in below.**
  - Your election of either Single, Two-Person or Family Coverage.

If electing coverage through a Teamster Affiliated Local Union, contact the appropriate Local Union office to obtain the forms necessary to enroll in their respective retiree health plans. The Local Union will notify the Fund Office of your enrollment and verify the Premium Assistance amount to be discounted from your monthly premium.

PLEASE BE ADVISED THAT UNTIL THE REQUIRED FORMS ARE FULLY COMPLETED, PROPERLY EXECUTED AND RETURNED TO THE FUND OFFICE OR TEAMSTER AFFILIATED LOCAL UNION, NEITHER YOU NOR YOUR BENEFICIARIES WILL BE ENTITLED TO ANY BENEFITS UNDER THE TERMS OF THE PLAN.

AVAILABLE INSURANCE PLANS

The available insurance plans are offered 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

You may choose any one of the following insurance plans:

The following PPO programs offered through Excellus BlueCross BlueShield provide in-network and out-of- network coverage:

- Excellus BCBS: Excellus Blue PPO Option I
- Excellus BCBS: Excellus Blue PPO Option K
- Excellus BCBS: Excellus Blue PPO Option C2

The following EPO program offered through Excellus BlueCross BlueShield provides in-network coverage only. (In-network includes all Excellus BlueCross BlueShield providers.):

- Excellus BCBS: Excellus Blue EPO Option B (In-Network Only)

Copies of the Summaries of Benefits and Coverage for the insurance plans referenced above are attached as Appendix "A".

You may also choose to participate in another Teamster-Affiliated local union health plan. You will want to review the materials these programs may provide and compare all of the elements of the program that may be important to you.

PREFERRED PROVIDER NETWORK

As indicated above, some of the insurance offerings are provided through a Preferred Provider Organization ("PPO") product administered by Excellus BlueCross BlueShield to provide medical benefits. 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".

Where services are rendered in the area of a BlueCross BlueShield organization other than EBCBS, the benefit payable under the Plan will depend on whether the Provider participates in the local BlueCross BlueShield PPO Network. Any In-Network Provider cannot "balance bill" the Plan participants for any amounts greater than your local BlueCross BlueShield payment amount. The Allowable Expense for payment of out-of-network claims will be determined by the Plan based on the lowest of (1) the professional provider's charge, (2) The amount approved by the other Blue Cross Blue Shield Plan [with whom the provider has an agreement], or (3) 100% of the payment Blue Cross Blue Shield of CNY makes to its participating providers for the type of care you receive, based on a regional fee schedule.

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 your local PPO Network, you will likely incur a greater level of out-of-pocket cost than if you had used an In-Network provider.

CLAIMS AND APPEAL PROCEDURES

The Premium Assistance Program benefits are administered by the Fund. If your claim for benefits is denied in whole or in part for any reason, then within 90 days after the Fund receives your claim, the Fund will send you written notice of its decision, unless special circumstances require an extension, in which case the Fund will send you written notice of the decision no later than 180 days from the date it receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the benefit determination.

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. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, 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.

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 administrators) 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.

To appeal an adverse benefit determination, you must contact the Fund Office in writing stating your desire to appeal the determination. You have 60 days to appeal such a claim.

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.

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

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.

The Trustees' final decision with respect to their review of your appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. Any legal action against this Plan must be started within one (1) year from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address. Please note that filing a lawsuit without exhausting the Fund's appeals procedures could limit your right to appeal or cause you to lose benefits to which you would otherwise be entitled.

Effective for claims filed on or after April 1, 2018, the following applies to any benefit determination conditioned on a finding of disability by the Plan. These rules do not apply to a determination conditioned on a finding of disability by a party other than the Plan (e.g. the Social Security Administration).

1. Adverse benefit determination notices will include the following:

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

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

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

        (3) 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. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

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. Each rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

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.

ADMINISTRATION AND FUNDING

Premium Assistance Program Benefits are self-funded and administered by:

The New York State Teamsters Council Health and Hospital Fund
P.O. Box 4928
Syracuse, New York 13221-4928