SUMMARY OF MATERIAL MODIFICATIONS
AND
NOTICE TO PARTICIPANTS

NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND

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

January 1, 2008

Dear Participant:

The following is updated language for your Health & Hospital Fund pertaining to the Claims and Appeal Procedures:

Section 6
CLAIMS AND APPEAL PROCEDURES

Initial Decisions and Adverse Benefit Determinations

The "initial decision" is the first notice you will receive from the Plan as to whether your benefits claim is covered by this Plan. 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 Plan; 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.

Procedures for Making Initial Decisions

Medical Benefits (Administered by BlueCross BlueShield of Central New York, Dental Benefits (Administered by EBS Benefits Solutions, Inc.), Prescription Drug Benefits (Administered by Medco Health Solutions, Inc.), and Vision Care Benefits (Administered by Vision Service Plan, 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 is described below.

Pre-Service Claims

A Pre-Service Claim is any claim with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. The only possible Pre-Service Claims are claims for Medical Benefits administered by BlueCross BlueShield of Central New York and Dental Benefits administered by EBS Benefits Solutions, Inc.

For Pre-Service Claims, you will be notified of the benefit determination by BlueCross Blue Shield of Central New York or EBS Benefits Solutions 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 BlueCross BlueShield of Central New York and Dental Benefits administered by EBS Benefits Solutions, Inc.

For Urgent Care Claims, you will be notified by the third-party administrators regarding the benefit determination (whether adverse or not) as soon as possible, and not later than 72 hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. You will be provided a reasonable amount of time to provide the specified information, but not less than 48 hours. Notification of the decision on that claim will then be provided within 48 hours after the 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. Claims for Vision Care Benefits and Prescription Drug Benefits are only Post-Service Claims. Certain claims for Medical Benefits and/or Dental Benefits administered are Post-Service Claims.

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

Concurrent Care Claims

A Concurrent Care Claim is a claim involving a pre-approved, ongoing course of treatment, including a request for extension of a course of treatment. The only possible Concurrent Care Claims are claims for Medical Benefits administered by BlueCross BlueShield of Central New York and Dental Benefits administered by EBS Benefits Solutions, Inc.

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 BlueCross BlueShield of Central New York or EBS Benefits Solutions, Inc. 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 Medco Health Solutions, Inc. at the following address:

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

If Medco Health Solutions, Inc. denies your claim, the rules regarding Post-Service Claims apply. If you need a claim form, or have any questions regarding these procedures, please call the Fund Office at (315) 455-9790.

Non-Occupational Weekly Disability Benefits (Administered by The Hartford Life Insurance Company)

The Non-Occupational Weekly Disability Benefits are administered by The Hartford Life Insurance Company ("The Hartford"). If your claim for Non-Occupational Weekly Disability Benefits is denied in whole or in part for any reason, then within 45 days after The Hartford receives your claim, The Hartford 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, The Hartford 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 Highmark Life Insurance Company of New York)

The Basic Life Insurance and Accidental Death and Dismemberment Insurance Benefits are administered by Highmark Life Insurance Company of New York (Highmark). If your claim for Basic Life Insurance or Accidental Death and Dismemberment Benefits is denied in whole or in part for any reason, then within 90 days after Highmark receives your claim, Highmark will send you written notice of its decision, unless special circumstances require an extension, in which case Highmark 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.

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.

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.

Procedures For Appeals

Time Frame For You To File An Appeal

Medical, Dental, Prescription Drug and Vision Benefit Claims:

To appeal an adverse determination of a Medical Benefit, Dental Benefit, Prescription Drug Benefit or Vision Benefit, you must file your appeal with the third-party administrator within 180 days after you receive the initial adverse benefit determination. For Medical and Dental claims other than Urgent Care claims, and Prescription Drug 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.

BlueCross BlueShield of Central New York or EBS Benefit Solutions, Inc. will decide all appeals of Urgent Care claims and the first level of appeals for Pre-Service and Post-Service claims. The Board of Trustees will decide 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 BlueCross BlueShield of Central New York, with respect to Concurrent Medical Benefit Claims or to EBS Benefit Solutions, Inc., with respect to Concurrent Dental Benefit 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, as applicable) 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.

Non-Occupational Weekly Disability Benefit Claims:

To appeal an adverse determination of a Non-Occupational Weekly Disability Benefit, you must contact The Hartford 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 Highmark in writing stating your desire to appeal the determination. Your correspondence should be directed to Highmark. 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 and Dismemberment Benefits 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 and Dental Benefits: These Medical Benefit claims are subject to a two-level appeal process, as noted above. At the first level of appeal, BlueCross BlueShield of Central New York or EBS Benefit Solutions, 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: BlueCross BlueShield of Central New York or EBS Benefit Solutions, Inc. 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 and Dental Benefits: These Medical Benefit claims are subject to a two-level appeal process, as noted above. At the first level of appeal, BlueCross Blue Shield of Central New York or EBS Benefits Solutions, 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.

Post-Service Claims for Prescription Drug Benefits. These Prescription Drug claims are subject to a two-level appeal process, as noted above. At the first level of appeal Medco 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 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: Appeals of adverse Basic Life Insurance and Accidental Death and Dismemberment Benefit Insurance determinations

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.

Non-Occupational Weekly Disability Benefits: Appeals of adverse Non-Occupational Weekly Disability 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 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.

All Other 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.

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

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

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

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

The Trustees' Decision is Final and Binding

The Trustees' (or their designee's) 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."

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 a benefit; adequate information of the activity involved to determine if the service or event is covered by the Fund; sufficient information, or

authorization to obtain information, to permit the Fund to make the dollar payment to the appropriate party. A verbal request for coverage will be considered received on the day of the conversation only if a written claim is received by the Fund or its third-party administrators within 48 hours of the time of conversation.

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 a adverse benefit determination regarding a claim. Documentary evidence may be in the form 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).

Please keep this information with your Health & Hospital Fund Summary Plan Description for permanent reference. If you have any questions regarding it, please contact the Fund Office at (315) 455-9790.

Sincerely,

BOARD OF TRUSTEES OF THE
NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND