SUMMARY OF MATERIAL MODIFICATIONS
AND
NOTICE TO PARTICIPANTS

NEW YORK STATE TEAMSTERS COUNCIL –
UNITED PARCEL SERVICE ("UPS") RETIREE HEALTH FUND

(Plan No.: 501; I.D. No.: 46-4111565)

May 4, 2022

Dear Participant:

The following is a notice describing recent changes to the Summary Plan Description ("SPD") for the New York State Teamsters Council – United Parcel Service ("UPS") Retiree Health Fund ("Fund" or "Plan"). You should keep this notice with your SPD for permanent reference. If you have any questions, please contact the Fund Office at 315-455-9790.

I. Section 4(A) – Major Medical Benefits, Preferred Provider Network

Effective January 1, 2022, this section has been replaced with the following:

"A. Preferred Provider Network

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

An In-Network Provider cannot "balance bill" you for any amounts greater than the amount EBCBS has negotiated with the In-Network Provider. The Allowable Expense for In-Network Providers is the amount EBCBS has

negotiated with the In-Network Provider or the In-Network Provider's charge, whichever is less.

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

II. Section 4(D) – Major Medical Benefits, Definitions

Effective January 1, 2022, the following definitions were added or changed as follows:

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

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

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

Surprise Bills, you must pay the difference between the Allowable Expense and the Out-of- Network Provider's charge.

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

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

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

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

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

Independent Freestanding Emergency Department) and such further medical examination and treatment as are required to stabilize the patient, regardless of the department of the Hospital in which further examination or treatment is furnished.

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

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

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

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

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

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

(1) Name, address and telephone number;

(2) Specialty;

(3) Board certification (if applicable);

(4) Languages spoken; and

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

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

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

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

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

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

III. Section 4(L) – Major Medical Benefits, Additional Benefits

Effective January 15, 2022, a new number (6) was added under "7. Novel Coronavirus (COVID-19) ("Coronavirus")" to provide that over-the-counter Coronavirus tests will be covered to the extent required by applicable law through the Plan's Prescription Drug Benefit.

IV. Section 4(Q) – Major Medical Benefits, Protection from Surprise Bills

Effective January 1, 2022, the following was added as new subsection Q:

"Q. Protection from Surprise Bills

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

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

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

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

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

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

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

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

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

(5) Diagnostic services, including radiology and laboratory services.

A Surprise Bill does not include a bill for healthcare services when an In-Network Provider is available and you elected to receive services from an Out-of-Network Provider or, with respect to non-Emergency Services (other than those specified above) performed by an Out-of-Network Provider in a participating Hospital, ambulatory surgical center or Independent Freestanding Emergency Department if the Out-of-Network Provider has obtained your consent to receive the services after providing

you with required notice and satisfying all other consent requirements applicable to the Out-of-Network Provider. If the Out-of-Network Provider follows the notice and consent requirements and you consent to receiving the services, the Plan's normal reimbursement rules with respect to Out-of-Network Providers will apply with regard to those services and you may be balance billed. Please see the definition of "Allowable Expense" for information about the Plan's normal reimbursement rules.

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

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

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

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

V. Section 4(R) – Major Medical Benefits, Transitional Care

Effective January 1, 2022, the following was added as new subsection R:

"R. Transitional Care

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. Section 4(O) – Major Medical Benefits, Exclusions

Effective January 1, 2022, the following was added at the end of subsection O:

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

VII. Section 4(P) – Major Medical Benefits, Submission of Claims

Effective January 1, 2022, the following was added at the end of the paragraph titled "Non-Participating Provider Claims":

"Payment for services rendered by an Out-of-Network Provider that are subject to the surprise billing protections as described in the "Protection

from Surprise Bills" section of the Plan will be made directly to the Out-of-Network Provider."

VIII. Section 10(F1) – Claims and Appeal Procedures, External Review

Effective January 1, 2022, the following was added as new subsection F1:

"**F1. EXTERNAL REVIEW**

You have the right to an "external review" of certain coverage determinations made by the Plan as described below and in more detail in subsection Q, titled "Protection from Surprise Bills," in the Major Medical Benefits section of this SPD booklet.

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

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

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

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

To be eligible for external review, the final adverse determination issued through the first level of the internal appeal process must be a determination involving consideration of whether the Plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act, which are described the subsection titled "Protection from Surprise Bills" in the Major Medical Benefits section of this SPD booklet.

Requesting an External Review

If you meet the conditions described above, you or your authorized representative may request an external review by completing and filing the required form with the Plan. The Plan will send the external review application to you with the notice of final adverse determination. You or your authorized representative will have the opportunity to submit additional information on the requested service; and you may be required to authorize the release of any medical records needed to reach a decision on the external review.

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

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

Effect of External Review Determination

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law.

However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Questions

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

IX. Section 10(G) – Claims and Appeal Procedures, The Trustees' Decision is Final and Binding

Effective January 1, 2022, subsection G was replaced with the following:

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

The Trustees' (or their designee's) or, if applicable, an external reviewer's, final decision with respect to the review of your appeal will be final and binding upon you.

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

Sincerely,

BOARD OF TRUSTEES
NEW YORK STATE TEAMSTERS COUNCIL –
UNITED PARCEL SERVICE ("UPS")
RETIREE HEATLH FUND