UPSTATE UNION HEALTH & WELFARE FUND

(BorgWarner Plan)

SUMMARY PLAN DESCRIPTION

JANUARY 1, 2019

GENERAL INFORMATION

The Upstate Union Health & Welfare Fund (BorgWarner Plan) is administered by a Board of Trustees. The address of the Board of Trustees is 566 Spencer Street, Syracuse, New York 13204. The telephone number is (315) 471-4164.

BOARD OF TRUSTEES

UNION TRUSTEES

Mark May
Duane Wright

EMPLOYER TRUSTEES

Salvatore Zavaglia
Douglas Shanks

FUND MANAGER

Kellie Mangan

FUND OFFICE

566 Spencer Street
Syracuse, NY 13204

Mailing Address:
P.O. Box 11037
Franklin Square Station
Syracuse, NY 13218

PLAN ATTORNEY

Blitman & King LLP
443 N. Franklin Street, Suite 300
Syracuse, NY 13204

HEALTH INSURANCE CARRIER

Excellus BlueCross BlueShield
P.O. Box 21146
Eagan, MN 55121

TO: PARTICIPANTS

FROM: TRUSTEES OF THE PLAN

DATE: JANUARY 1, 2019

This booklet is a description of the Plan as in effect on January 1, 2019. You will find that the benefits are described, as well as the eligibility requirements that you must satisfy with respect to each of them.

You should read this booklet thoroughly to make sure that you are completely familiar with the details of the Plan.

To give you an idea of our role with regard to the Plan, you should know that we are responsible for collecting and administering the contributions to the Plan which are required by agreement between your employer and Teamsters Local Union 317 or between your employer and the Trustees. In addition, we are required to formulate and administer the provisions of the Plan itself.

The Trustees are assisted in these tasks by professional advisors whom we hire from time to time.

The daily operation of the Plan is maintained by the Fund Manager located at the Fund Office. You are encouraged to make use of the facilities of the Office, where you will find assistance in understanding your benefits.

It is our intention to operate the Plan in a sound and successful manner. Your assistance in this endeavor will be increased by your complete understanding of the Plan itself. Accordingly, it is in your interest and that of your family to familiarize yourself completely with this booklet.

If, after having gone through this booklet thoroughly, you have any questions regarding the Plan or its operation, please do not hesitate to contact the Fund Manager.

Sincerely,

The Board of Trustees

IMPORTANT ASPECTS OF YOUR PLAN

- FAMILIARIZE YOURSELF WITH THE WHOLE BOOKLET.

- YOU MUST APPLY FOR ALL BENEFITS

- MAKE SURE THAT THE FUND OFFICE IS AWARE OF ALL YOUR DEPENDENTS AND YOUR CURRENT ADDRESS.

- ALL CLAIM FORMS MUST BE COMPLETELY FILLED IN; INCOMPLETE ONES WILL BE RETURNED.

IMPORTANT NOTICE

In the event there appears to be a conflict between the description of any Plan provisions in this booklet, and the terms and provisions of any insurance contract or certificate (which may be inspected at the Fund Office), the language contained in the insurance contract or certificate is the official and governing language.

CAUTION

This booklet and the Fund Manager are authorized sources of Plan information for you. The Trustees have not empowered anyone else to speak for them with regard to the Plan. No employer, union representative, supervisor or shop steward is in a position to discuss your rights under this Plan with authority. No oral statements by Plan personnel or any other Plan representative may modify in any respect the written terms of the Plan.

COMMUNICATIONS

If you have a question about any aspect of your participation in the Plan, you should, for your own permanent record, write to the Fund Manager or the Trustees. You will then receive a written reply, which will provide you with a permanent reference.

NO GUARANTEE OF INCOME TAX CONSEQUENCES

Neither the Board of Trustees nor the Fund Office makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for Federal or State income tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each Payment under the Plan is excludable from the Participant's gross income for Federal and State income tax purposes, and to notify the Fund Office if the Participant has reason to believe that any such Payment is not so excludable.

PLAN INTERPRETATIONS AND DETERMINATIONS

The Board of Trustees is responsible for interpreting the Plan and for making determinations under the Plan.

In order to carry out their responsibility, the Trustees, or their designees, have exclusive authority and full discretion: to determine whether an individual is eligible for any benefits under the Plan; to determine the amount of benefits, if any, an individual is entitled to from the Plan; to determine or find facts that are relevant to any claim for benefits from the Plan; to interpret all of the Plan's provisions; to interpret all the provisions of the Summary Plan Description (the "Plan"); to interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement involving or impacting the Plan; to interpret the provisions of the Trust Agreement governing the operation of the Plan; to interpret all of the provisions of any other document or instrument involving or impacting the Plan; and, to interpret all of the terms used in the Summary Plan Description, and in all of the other previously-mentioned agreements, documents, and instruments.

All such interpretations and determinations made by the Trustees, or their designees, shall be final and binding upon any individual claiming benefits under the Plan and upon all Participants, all Employers, the Union, and any party who has executed any agreements with the Trustees or the Union; will be given deference in all courts of law, to the greatest extent allowed by applicable law; and, will not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designees, abused their discretion in making such determination or rendering such interpretation.

BENEFITS UNDER THIS PLAN WILL BE PAID ONLY IF THE TRUSTEES DECIDE IN THEIR DISCRETION THAT YOU ARE ENTITLED TO THEM.

FUTURE OF THE PLAN, PLAN CHANGE, AND PLAN TERMINATION

This Summary Plan Description includes information concerning the circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of benefits that a participant or beneficiary might otherwise reasonably expect the Plan to provide. We refer you to the terms of this booklet which detail the eligibility rules, qualification rules, benefits, limitations and exclusions from coverages.

It is anticipated that the Plan will remain in effect indefinitely. However, the right to amend or modify the Plan is reserved by the Board of Trustees, in accordance with the Trust Agreement. In addition, the continuance of the Plan is subject to the maintenance of collective bargaining agreements which provide for employer contributions to the trust fund that provides the Plan benefits.

If it ever becomes necessary to terminate the Plan at some future date, the Trust Agreement provides that assets then held by the Trustees must be used exclusively on behalf of Plan participants and to defray the cost of reasonable administration and termination expenses. In no event will any of the assets revert to any employer or to the union. In the event of termination of the Plan, the Plan's assets are to be used exclusively for the benefit of participants in the Upstate Union Health & Welfare Fund.

Upon final liquidation of the Plan, participants and beneficiaries would have no further rights or vested interest in the Plan. The Trustees reserve the right to change or discontinue the types and amounts of benefits under the Plan and the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Benefits provided by the Plan:

- are not guaranteed;
- are not intended or considered to be deferred income;
- are not vested;
- are contingent upon the right of the Trustees to make modifications or terminated such benefits;
- are subject to the rules and regulations adopted by the Trustees; and
- may be modified or discontinued and such modification or termination right is not contingent on financial necessity.

The benefits and eligibility rules applicable to Plan participants, and dependents have been established by the Trustees as part of an overall benefit Plan for participants. The right to amend or modify the eligibility rules and benefits for participants and/or dependents is reserved by the Trustees. The continuance of benefits for any class of participants and the eligibility rules relating to qualification therefore are subject to modification and revision by the Trustees in accordance with their responsibilities.

In accordance with the rules and regulations of the Plan and the Trust Agreement, no employee or dependent has a vested interest in the benefits provided.

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PART A

GENERAL INFORMATION

INTRODUCTION

This Summary Plan Description describes the provisions of the Plan. Notice that the eligibility requirements that you must satisfy in order to participate in, and be entitled to, a benefit may be different for each of the benefits.

IN GENERAL

The Upstate Union Health & Welfare Fund is maintained through Collective Bargaining Agreements with Teamsters Local Union 317. These Collective Bargaining Agreements provide that employers must contribute to the Fund on behalf of each Covered Employee. Employer Contributions are also made pursuant to certain Participation Agreements between the Employer and the Fund.

ELIGIBILITY REQUIREMENTS

Your coverage depends upon the timely receipt by the Fund of the required premiums for your benefits and you satisfying the general eligibility requirements in your current period of Plan participation. Your eligibility terms for benefits are set forth in the collective bargaining agreement or participation agreement that applies to your employment. Those eligibility provisions must comply with the Affordable Care Act. The Fund's Trustees will decide all questions about eligibility, and their decisions will be final and binding on you. You may also be eligible for BorgWarner's other group health coverage, currently the CIGNA Choice Health Fund. For more information regarding the CIGNA Choice Health Plan, you should contact BorgWarner directly. Please note you are not eligible for coverage under this Plan if you are enrolled in BorgWarner's other group health insurance.

In order to receive benefits from the Fund, you must provide to the Fund Office any requested documentation that the Fund Office decides is necessary to determine your entitlement to benefits, including, but not limited to, documents that demonstrate your age. Examples of such documentation include, but are not limited to, the completed enrollment form, birth certificates, marriage certificates, death certificates, baptismal certificates, Census Bureau notifications of birth registration, hospital birth records, military records, passports, certified public school records, marriage licenses, court orders or notarized affidavits confirming name changes, and divorce decrees. Failure to provide the requested documents may delay or preclude entitlement to benefits. You must make sure that all the information and documents that you provide to the Fund Office are true, correct, and complete. Your right to coverage from the Fund is based on the condition that all the information and documents that you provide to the Fund are true, correct, and complete.

ELIGIBLE DEPENDENTS

Under this Plan, your legal spouse qualifies as an eligible dependent.

A person will also qualify as an eligible dependent if he or she: (1) is your child (son, daughter, stepson, stepdaughter, adopted, or foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction); and (2) is age 25 or younger or is permanently and totally disabled. For a child who is permanently and totally disabled to be covered beyond the normal age limits, that unmarried child must have been covered by the Plan and been incapable of self-sustaining employment due to a total and permanent mental or physical disability before the beginning of the calendar year in which he or she attains age 26. Your disabled child will be carried beyond the age restrictions of this Plan as an eligible dependent as long as the child is disabled and covered under the Plan when reaching age 26, the child's condition remains the same, the child does not provide over one-half of his or her own support for the taxable year, and the child lives with you for more than one-half of your taxable year and you continue to be covered.

Please note, under New York State law, health insurance coverage may be available to your unmarried children through the age of 29 years if they are living or working in their parent's health Plan service area and not otherwise insured or eligible for health insurance through their own employers or covered by Medicare. A separate premium will be charged for this coverage. Coverage ends when you (the parent) are no longer enrolled in this Plan, your adult child no longer meets the eligibility requirements, or the premium for their coverage is not paid in full within the required time period.

The Fund will also provide benefits pursuant to the terms of any Qualified Medical Child Support Order. A QMCSO is a court decree under which a court order 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 "alternate recipients." Both you and your beneficiaries can obtain, without charge, a copy of the Plan's QMCSO procedures from the Fund Manager.

Upon receipt of a medical child support order, the Fund Manager will promptly notify the participant and each child of receipt of the order. The participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be considered a participant under the Health fund and will receive copies of summary Plan descriptions, summary annual reports, and summaries of any amendments made to the Plan according to current ERISA requirements.

In order to receive benefits from the Fund, you must provide to the Fund Office any requested documentation that the Fund Office decides is necessary to determine entitlement to benefits for your dependents, including, but not limited to, documents that demonstrate the age of your dependents and their relationship to you. Examples of such documentation include, but are not limited to, the completed enrollment form, birth certificates, marriage certificates, death certificates, baptismal certificates, Census Bureau notifications of birth registration, hospital birth records, military records, passports, certified public school records, marriage licenses, divorce decrees, court orders or notarized affidavits confirming name changes, and Qualified Medical Child Support Orders. Failure to provide the requested documents may delay or preclude entitlement to benefits. You must make sure that all the information and documents that provide to the Fund Office are true, correct, and complete. Your right to coverage from the Fund is based on the condition that all the information and documents that you provide to the Fund are true, correct, and complete.

PART B

DESCRIPTION OF BENEFITS

HEALTH INSURANCE BENEFIT

The Health Insurance Benefit is available to eligible participants and eligible dependents.

The Health Insurance Benefit of the Plan is provided through Excellus BlueCross BlueShield. Detailed descriptions of the benefits are provided to you by the carrier. In case of any conflict between this Summary Plan Description and the applicable BlueCross BlueShield policy/contract, incorporated by reference herein, the provisions of the policy/contract control. A copy of the contract may be obtained from the Fund Office upon request.

Once you satisfy the eligibility requirements, you will be given information concerning your Excellus BlueCross BlueShield health insurance Plan options. To enroll in coverage, you will be required to complete an insurance form. Health insurance coverage may be delayed pending your completion, and the Fund Office's receipt of, the required forms.

Once enrolled, as part of your benefits, you will have access to Telemedicine services (800-Teladoc [800-835-2362]). Participants and their eligible dependents enrolled in Medical Benefits may utilize the Teladoc Telemedicine Program for appropriate covered services. The Program provides on-demand or by appointment doctor visits by telephone or web-based video with participating physicians.

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

ENROLLMENT

Participation in the Fund is not automatic. You need to enroll. It is your responsibility to obtain, complete and return to the Fund Office enrollment documents which include your enrollment application.

WHEN EMPLOYEE COVERAGE ENDS

Your coverage will continue so long as you remain eligible under the terms of the applicable collective bargaining agreement and there is a sufficient amount timely contributed on your behalf to pay the premiums for your coverage.

PART C

CLAIM PROCEDURES

CLAIM REVIEW AND APPEAL PROCEDURES

FILING OF CLAIMS

Claims for the insured benefits should be filed in accordance with certificates/policies issued by the respective carrier/administrator. Those claims should be filed, if not resolved at the point of service, with the respective carrier/administrator.

Claims for all other benefits must be submitted to the Fund Office within one year of the date of service unless otherwise indicated in this SPD.

Note, the Trustees of this Plan, their designee or the insurance company providing benefits have the right and opportunity to examine any claimant when and as often as they may reasonably require. The claimant will furnish to the Trustees, their designee, or the insurance company providing benefits such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to comply with such requests properly and in good faith will be sufficient grounds for delaying or denying the payment of benefits. The Trustees, their designee or the insurance company providing benefits will be the sole judge of the standard of proof required in any case and they may from time to time adopt or modify such formulas, methods and procedures as they consider advisable.

As described below, if your claim for a benefit has been denied, you may appeal in writing for a review of that decision in accordance with the following procedures.

To the extent there is any conflict between the procedures in this SPD and the insurance policy, contract or certificate for the benefit in question, the terms of that policy, contract or certificate control. You should check the appropriate policy, contract or certificate prior to filing any claim or appeal.

Claim Denial and Appeal

Initial Decisions

Time Frames

Note, for health care claims, the rules that apply depend on the type of claim. There are four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service. 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. An Urgent Care Claim is a Pre-Service Claim for medical care or Treatment in which application of the time periods for making nonurgent 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. 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. 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.

Post-Service Claims

In general, you will be notified of any adverse benefit determination by the insurance company for any insured benefits and by the Fund Office, or its designee, for any self-insured benefits within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended for up to 15 days for matters beyond the insurance company's or the Fund Office's control if, before the end of the initial 30-day period, the insurance company or the Fund Office, or its designee, notifies you of the reasons for the extension and of the date by which the insurance company or the Fund Office, or its designee, 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.

Pre-Service and Urgent Care Claims

For pre-service claims generally, you will be notified by the insurance company or the Fund Office regarding the benefit determination (whether adverse or not) within a reasonable period, but not later than 15 days after receipt of the pre-service claim. The 15-day period may be extended for up to 15 days for matters beyond the insurance company's (or the Fund Office, or its designee) 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 insurance company (or the Fund Office, or its designee) 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 the claimant 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 insurance company (or the Fund Office, or its designee) will provide notice of the failure within 15 days.

For urgent care claims, you will be notified by the insurance company (or the Fund Office, or its designee) 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. The insurance company (or the Fund Office, or its designee) will then provide notification of the decision on that claim within 48 hours after receipt of the specified information or the end of the additional period afforded you provide such information.

Concurrent Care Claims

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a previously approved claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, your request will be treated in the same manner as urgent care claims.

Content of Notification of Initial Adverse Benefit Determination

Depending on the type of benefit involved with the claim, this notice will either come from the insurance carrier or the Fund Office (or its designee). The initial notification of adverse benefit determination will include:

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 a case of an adverse determination involving a 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, 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;

7. If the adverse benefit determination 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;

8. Information sufficient to identify the claim involved. This information includes the date of service, health care provider, and the claim amount (if applicable);

9. The denial code, if applicable, and its corresponding meaning;

10. A statement of your right to request any diagnosis code, treatment code, and the corresponding meanings of those codes in connection with adverse benefit determinations. However, a request for this information will not be treated as a request for a voluntary appeal or external review;

11. A description of the Plan's or issuer's standard that was used in denying the claim;

12. A detailed description of the available external review processes; and

13. The availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793 to assist enrollees with the internal claim and appeal processes and external review processes.

Further, additional internal appeal procedures include the following:

1. "Adverse Benefit Determination" includes "rescission of coverage." "Rescission" defined as a cancellation or discontinuance of coverage that has a retroactive effect.

2. You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated 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 final internal adverse benefit determination is required to be provided.

3. Before a final internal adverse benefit determination is issued based on new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided.

4. Notice of an adverse benefit determination will be made in a "culturally and linguistically appropriate manner" when required by law.

5. If any of the internal appeal rules are not followed, you may be deemed to have exhausted the internal claims and appeals process, and may initiate any available external review process or remedies available under ERISA or under State law unless the Plan's violation is: (a) de minimus, (b) non-prejudicial, (c) attributable to good cause or matters beyond the Plan's control, (d) in the context of an ongoing good-faith exchange of information, and (e) not reflective of a pattern or practice of non-compliance. You may request a written explanation of the violation and will be provided such explanation within 10 days, including, if applicable, a specific description of the basis for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

Appeals of Adverse Benefit Determinations

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal the initial adverse benefit determination. To appeal an insured benefit, you must follow the procedures set forth in the underlying insurance policy which may be obtained from the Fund Office upon request.

To appeal an adverse benefit determination of any other benefit, you must write to the Trustees, or their designee, within 180 days after you receive this Plan's initial determination

For appeals to the Board of Trustees, the following rules apply. 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. 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. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do not want to communicate about your situation to someone unless they are sure he or she is your chosen representative.

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: (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 Board 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 upon request.

Determinations on Appeal

Time Frames

Insured Benefits: Please note that appeals involving the insured portion of your benefits will be decided in accordance with ERISA regulations and the appeal procedures contained in the appropriate underlying insurance policy which may be obtained from the Fund Office upon request.

All Other Appeals: Except as described below, the Trustees at their next regularly scheduled meeting, or their designee, will make a determination on appeal. For appeals decided by the Trustees, 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 Trustees will notify you of the benefit determination not later than 5 days after the determination is made.

Pre-Service and Urgent Care Self-Insured Claims. Pre-Service claims, except for urgent care claims, are subject to a distinct appeal process. For most Pre-Service claims, the Trustees, or their designee, 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.

For urgent care claims, however, the Trustees, or their designee, will decide and communicate to you the decision concerning any appeals related to Pre-Service Claims taking into account medical exigencies, but not later than 72 hours after receipt of the request for review.

For Concurrent Care Claims: A determination will be made before termination of your benefit.

Content of Adverse Benefit Determination Notice on Review

Depending on the type of benefit involved with the claim, this notice will either come from the insurance carrier or the Trustees (or their designee). This notice 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;

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;

7. Information sufficient to identify the claim involved. This information includes the date of service, health care provider, and the claim amount (if applicable);

8. The denial code, if applicable, and its corresponding meaning;

9. A statement of your right to request any diagnosis code, treatment code, and the corresponding meanings of those codes in connection with adverse benefit determinations. However, a request for this information will not be treated as a request for a voluntary appeal or external review;

10. A description of the Plan's or issuer's standard that was used in denying the claim. If the notice involves a final internal adverse benefit determination, the description will also include a discussion of the decision;

11. A detailed description of the available external review processes; and

12. The availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793 to assist enrollees with the internal claim and appeal processes and external review processes.

External Review

You should inquire with the insurance carrier for details regarding its external review program and your eligibility for the program.

You have the right to external review of an adverse benefit determination within 4 months after receipt of the notice of the adverse determination. In general, for purposes of external review eligibility, an "adverse benefit determination" is a benefit denial that involves medical judgment, or a rescission of coverage.

The external review will be made by an independent review organization with health care professionals that have no conflict of interest with respect to the benefit determination. Except for approved expedited external reviews this external review is available once you have exhausted the internal grievance process. For self-insured benefits, any request for external review must be in writing and submitted to the Fund Office within four months after receipt of the notice of the adverse determination. Upon application and approval of the request for external review, the Fund Office will assign an independent review organization. Please do not hesitate to contact the Fund Office with any questions regarding external review.

Disability Claims and Appeals

The following also 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 (for example, the Social Security Administration).

Adverse benefit determination notices will also include the following:

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

    a. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

    b. 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

    c. A Social Security Administration disability determination regarding the claimant, presented by the claimant to the Plan.

2. 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;

3. 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

4. For appeal determinations, any contractual limitations period for filing a civil action and the calendar date deadline for doing so.

The Trustees' Decision is Final and Binding

The Trustees' (or their designee's) final decision with respect to their review of your appeal, or, if you are eligible for, and pursue, External Review, the External Reviewer's final decision with respect to its review of your claim, will be final and binding upon you because they 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 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address by the Trustees (or their designee) or, if you pursue External Review, by the External

Reviewer; such action may only be started after all administrative procedures set forth in the Plan have been exhausted by the Participant. Notwithstanding anything to the contrary herein, you may not assign, convey, or in any way transfer your right to bring a lawsuit against the Plan, or its Trustees, to anyone else.

Overpayments and Mistaken Payments...

In the event that a participant or a third party is paid benefits from the Fund in an improper amount or otherwise receives Plan assets not in compliance with the Plan (hereinafter overpayments or mistaken payments), the Fund has the right to start paying the correct benefit amount. In addition, the Trustees have the right to recover any overpayment or mistaken payment made to a claimant (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 Fund with interest at 12% 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 Fund for attorneys' fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Fund 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.

INCOMPETENCE

If the Trustees (or their designee) determine that a person entitled to benefits from the Plan is unable to care for his or her affairs because of illness, accident, or incapacity (either physical or mental), payment which would otherwise be made to that person shall be made to that person's duly appointed legal representative. In the event no legal representative shall have been appointed, such payment shall, in the discretion of the Trustees (or their designee), be made to that person's spouse, child or such person who shall have care and custody of that person.

COOPERATION

Every claimant will furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may from time to time adopt such formulas, methods, and procedures as they consider advisable.

MAILING ADDRESS OF CLAIMANT

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with the claimant at the address last recorded by the Trustees and a letter sent by first class mail to such claimant is returned, and payments due the claimant will be held without interest until payment is successfully made.

COORDINATION OF BENEFITS

Coordination of Benefits is a series of rules, which apply if a person is eligible under another Plan providing medical benefits as well as under this Plan. This frequently happens when both the Participant and the Participant's spouse work. The Coordination of Benefits rules

determines the portion of the expenses, which will be paid by each Plan. They will not reduce your total benefit in any way.

This set of rules is used to determine whether this Plan or the other Plan will be the "primary Plan" and pay benefits first. If this Plan is the primary Plan, it determines the benefit payable regardless of the provisions of any other Plan. If this Plan is the secondary Plan, it will pay benefits only after the primary Plan has determined what it will pay.

If you or your dependent is covered under another health care Plan, the total amount received from all Plans will never be more than 100% of Allowable Charges. Benefits are reduced only to the extent necessary to prevent any person from making a profit on his coverage. Allowable Charges are any necessary and reasonable expenses for medical services, treatment, or supplies, covered by one of the Plans under which you or your dependents are covered.

A "health care Plan" is any group providing health care coverage on an insured or uninsured basis. This includes but is not limited to group BlueCross BlueShield, labor-management trustee Plans, union welfare Plans, employer Plans, and any coverage under governmental programs, student insurance Plans, and no-fault auto insurance.

If the other Plan does contain a Coordination of Benefits provision, this Plan will be the primary Plan if the person incurring the expense is covered by this Plan as an employee. If the person incurring the expense is covered by this Plan as a dependent, this Plan will be the secondary Plan if the other Plan covers such person as a covered employee.

In cases involving the children of a Participant, benefits are determined by reference to the parents' birthdays. If your children are eligible for coverage under this Plan and a Plan provided by your spouse's employer, this Plan will be the primary Plan if your birthday falls earlier in the year than your spouse's birthday. If you happen to have the same birthday, this Plan will be the primary Plan if it has covered you longer than your spouse's Plan has covered your spouse. If a court order requires someone or some entity other than this Plan or its Participant to provide health coverage, then such court order shall be honored.

It is your obligation to notify the Plan if you, your spouse, or any of your dependents are covered by another health care Plan. If you fail to do so, any amount by which the Plan overpays benefits will be recovered from you, either directly, or through a reduction in future benefits.

Coordination with Medicare...

In general, to the extent required by applicable law, if you are covered by this Plan as an active Employee and this Plan is receiving Employer contributions on your behalf, then this Plan will be primary and Medicare will be secondary, to the extent you are also entitled to coverage under Medicare. If you suffer from end stage renal disease before age 65, Medicare will be primary after the coordination period described in the regulations of the Department of Health and Human Services.

Family and Medical Leave Continuation Coverage...

Under the Family and Medical Leave Act, you may be eligible for up to 12 weeks of unpaid leave for any of the following reasons:

(1) To care for your newly born or adopted child;

(2) To care for your spouse, child or parent who has a serious health problem; or

(3) If you have a serious health problem which prevents you from performing your job.

Your Employer must notify the Fund that you are on leave for one of the purposes described in the Act and continue to make contributions on your behalf.

While you are on leave, you (and your eligible dependents, if any) will continue to participate in the Plan just as if your employment had not stopped, unless your Employer fails to make the required contributions for you.

Your eligibility for continued benefits under the Family and Medical Leave Act will be terminated upon the occurrence of any 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 leave which you are entitled to under federal law; or

(3) You or your Employer notify the Fund that you do not intend to return to the Employer's employment. (NOTE: If you do not return to work for your Employer at the end of your leave, you may be responsible for repaying the Employer contributions made for you during the leave.)

SUBROGATION

General Rights of Subrogation and Reimbursement...

NOTE: This provision applies to all Participants and their covered spouses and dependents, with respect to all of the Benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all Participants, covered spouses, and covered dependents.

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury or is otherwise responsible for your medical bills or other benefits provided from the Plan. The rules in this section govern how this Plan pays Benefits in such situations.

These rules have two purposes. First, the rules ensure that your Benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit this Plan to pay your covered expenses and provide any other benefits to which you are entitled until your dispute with the third party is resolved. However, the Trustees, in their discretion, may determine not to provide benefits under the Plan for you if a third party may be responsible for the Payment of benefits, until a determination is made by the proper and final decision-maker regarding the third party's responsibility to you.

Second, the rules protect this Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the Benefits it has advanced to you out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses. Reimbursement to the Plan shall take place regardless of how the recovery is characterized, including, but not limited to, pain and suffering. The Plan's rights of subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault or the common-fund doctrine. The Trustees have the right to seek all available relief to the extent permitted by applicable law. In

enforcing the Plan's rights to subrogation and reimbursement, the Trustees are not bound by any determination made by any other person or entity including, but not limited to, the Court, Arbitrator, Hearing Officer or similar person or entity with regard to the Fund's entitlement. In other words, the Trustees will be the sole determiners of the Plan's right to subrogation and reimbursement.

Rights of Subrogation and Reimbursement...

If you incur covered expenses for which a third party may be liable or if you become entitled to other benefits as a result of the same events which cause you to incur the covered expenses, you are required to advise the Plan of that fact. By law, the Plan automatically acquires any and all rights, which you may have against the third party.

You and/or your attorney must keep the Administrator of the Fund apprised in writing of the status of the third party action. Additionally, you and/or your attorney agree that, prior to any settlement of the third party matter, the Fund must consent to the terms and conditions of the settlement. The Participant or dependent and the attorney must authorize such third party or its insurance company to pay the Fund directly out of the proceeds of any recovery, verdict, judgment or settlement, prior to the payment of any such proceeds to the Participant or dependent, their agent or attorney.

In addition to its subrogation rights, the Plan has the right to be reimbursed in full for payments made to you or on your behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment, or other payment that you obtain from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment regardless of how you or the court characterize the nature of the recovery. Your attorney must agree that no attorney fees, expenses or costs of any kind will reduce the Fund's lien in this matter.

The Plan has no responsibility to contribute to the Payment of your attorneys' fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

The Trustees may, in their sole discretion, require the execution of this Plan's lien forms by you (or your authorized representative if you are a minor or if you cannot sign) before this Plan pays you any Benefits related to such expenses. If the Trustees have required execution of the Plan's lien forms, no Benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney since that attorney must also execute the form

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORMS DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHTS OF SUBROGATION AND REIMBURSEMENT.

The Plan's Reimbursement and Subrogation Agreement must be signed by you and your attorneys and received at the Fund Office on the earlier of either (1) one year from the date of your accident; or (2) thirty (30) days after the date of the letter from the Fund Office forwarding the Reimbursement and Subrogation Agreement to be signed or no Benefits will be paid by the Plan for the expenses related to that accident.

You must also: (1) provide the Fund Office with quarterly reports regarding status of your third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and (2) promptly respond to any inquiries from the Fund regarding the status of the third party claim or action including, but not limited to, motions,

depositions, pretrial conferences, trial dates, settlement conferences, etc. Your duty to provide this information to the Plan is a continuing one.

Right of Future Subrogation and Reimbursement...

In addition to satisfaction of the existing lien from any recovery received by the Participant, spouse and/or dependent, the Fund is also entitled to a future credit for future causally-related Plan expenses equal to the net monies received by the Participant, spouse, and/or dependent. As such, the Participant, spouse, and/or dependent must spend the net recovery on causally-related Plan expenses until the amount of said net recovery is exhausted.

It is only at that point that the Participant's, spouse's, and/or dependent's further Plan benefits will again be the responsibility of the Fund pursuant to the terms of the Plan. The Fund will not resume payment of medical and related benefits until such time as you have provided the Fund with proof that you have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Fund Office will determine the net monies available for a future credit.

Assignment of Claim...

You may not assign any rights or causes of action that you may have against any third-party tortfeasor without the express written consent of the Plan. The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Plan. If this Plan recovers from the third party any amount in excess of the Benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

Failure to Disclose and/or Cooperate...

If you fail to tell this Plan that you have a claim against a third party; if you fail to assign your claim against the third party to this Plan when required to do so (and to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's lien forms; if you and/or your attorneys fail to reimburse this Plan out of any payment you obtain from the third party; if you fail to provide the Plan with medical or other authorization to obtain the necessary information; if you or your attorneys fail to file written quarterly reports regarding your case with the Fund Office; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if this Fund reduces the amount of its lien or otherwise limits it rights); then you are personally liable to this Plan for the reimbursement owed to this Plan by the third party as well as for the Plan's attorney's fees and costs incurred in recovering that amount. This Plan may offset the amount you owe from any future benefit claims, or, if necessary, take legal action against you. The reimbursement owed to the Plan shall also, in the Trustees' discretion, be considered an overpayment or mistaken payment and must be repaid as provided in the section of this Plan dealing with "Overpayments and Mistaken Payments." **The Board of Trustees has the sole discretion to determine whether you and your attorney have cooperated with the Fund's efforts to recover the entire amount of its lien.**

Automobile Insurance Claims...

If you or one of your eligible dependents are injured in a motor vehicle or motorcycle accident and you or they are covered by medical benefits through your automobile policy or another driver's insurance benefits, this Plan will pay last as a Reimbursement Plan. When such claims are covered by Personal Injury Protection (P.I.P.) the claim must be submitted to the P.I.P. carrier before any payments may be made by the Fund Office.

If a delay in payment occurs due to legal requirements, our Plan may reimburse you under the terms of a Reimbursement and Subrogation Agreement for the claim as submitted and, if and when the claim is settled by your automobile insurance company or any other insurance company, reimbursement to our Plan will be required under the terms of the Subrogation Agreement.

PART D

MISCELLANEOUS

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your Protected Health Information ("PHI") effective April 14, 2003. A summary of your rights under HIPAA can be found in the Plan's privacy notice, which will be distributed to you in accordance with HIPAA and which is available from the Plan's Privacy Official, Kellie Mangan, Fund Manager.

This Plan, and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is the Board of Trustees), will not use or disclose your PHI except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law.

"Payment" includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of Plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

(a) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and co-payments as determined for a participant's claim);

(b) coordination of benefits;

(c) adjudication of health benefit claims (including appeals and other payment disputes);

(d) subrogation of health benefit claims;

(e) COBRA contributions;

(f) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(g) billing, collection activities and related health care data processing;

(h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(i) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(j) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(k) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(l) disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health Plan); and

(m) reimbursement to the Plan.

"Health Care Operations" include, but are not limited to, the following activities:

(a) quality assessment;

(b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(c) rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(d) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(e) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(f) business management and general administrative activities of the Plan, including, but not limited to:

(1) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements

(g) resolution of internal grievances; and

(h) due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the merger, will become a covered entity.

The employees of the Fund who assist in the Plan's administration and the Board of Trustees of the Upstate Union Health & Welfare Fund will have access to your PHI. However, these individuals may only have access to use and disclose your PHI for Plan administration functions. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

The Plan will not, without your authorization, use or disclose your PHI for employment related actions and decisions or in connection with any other benefit or employee benefit Plan of the Plan Sponsor.

HIPAA provides that this Plan may disclose your PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not use or further disclose the information other than as permitted or required by the Plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment related actions and decisions unless authorized by you; (d) not use or disclosure the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by you; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) make PHI available to you in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

If a breach of your PHI occurs, the Plan will notify you.

To ensure the protection of your PHI, the Plan Sponsor will:

(a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

(b) ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) report to Plan any security incident of which it becomes aware concerning electronic protected health information.

This Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact, Kellie Mangan, Fund Manager and Privacy Official at (315) 471-4164 if: (a) you wish to obtain a copy of the notice; (b) you have questions about the privacy of your health information; or (c) you wish to file a complaint under HIPAA.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with this Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Military Service...

If you enter qualifying military service, as determined by federal law, you and your eligible dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under federal law. This coverage, subject to the provisions of the Plan, will last for up to twenty-four (24) months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the twenty-four (24) month period if you enter military service and are discharged earlier and you fail to make a timely application for re-employment upon discharge.

If you elect such continuation coverage, you will not be required to pay any premium for the first thirty days of such coverage. However, thereafter, and until the cessation of such coverage, the required monthly premium plus a two percent (2%) administrative charge will need to be timely remitted.

Special Enrollment Rights...

By law, the Plan must provide the following description of special enrollment rights to anyone who becomes eligible for coverage: If you decline enrollment for yourself or your 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 30 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.

STATEMENT OF ERISA RIGHTS

As a participant in the Upstate Union Health & Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine without charge, at the Plan Administrator's Office or at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series)

filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual fiscal report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court after exhausting the Plan's internal claims procedures. 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 it should happen that Plan fiduciaries misuse the Plan's money, or if you are 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.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, of if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, JFK Federal Building,

Room 575, Boston, Massachusetts 02203, (617) 565-9600 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.

The Department of Labor requires that this Summary Plan Description contain this description of your ERISA rights. Its inclusion in this Summary Plan Description is not, and should not be considered to be offered as legal advice of any kind. For legal advice, you should consult with a licensed attorney.

Mothers and Newborns

The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for a mother or newborn child to (1) less than 48 hours following normal vaginal delivery; or (2) less than 96 hours following a Caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The Plan may not require that an attending provider such as your physician obtain additional authorization for prescribing a length of stay within these limits.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act, which was signed into law in 1998, provides that any group health plan that provides medical and surgical benefits with respect to a mastectomy must also provide coverage for reconstructive surgery following the mastectomy. Specifically, if a participant or beneficiary is receiving benefits in connection with a mastectomy, the Plan must also provide the following coverage if elected in connection with the mastectomy, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complication at all stages of mastectomy, including lymphedemas.

The deductibles and coinsurance limitations concerning the coverage specified under the Women's Health and Cancer Rights Act are set forth in the insurance policy which applies to your coverage.

COBRA CONTINUATION COVERAGE

WHAT IS COBRA CONTINUATION COVERAGE?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop. Your spouse and your dependent children may elect COBRA Continuation Coverage even if you do not.

WHICH EMPLOYEES ARE ELIGIBLE FOR COBRA CONTINUATION COVERAGE?

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of health insurance coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer

meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff.

WHEN IS MY SPOUSE ELIGIBLE FOR COBRA CONTINUATION COVERAGE?

Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following events:

1. Your death.

2. Your spouse's loss of coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout, or layoff.

3. Divorce or judicial order of legal separation.

4. Your enrollment in Part A or Part B of Medicare.

WHEN DOES MY DEPENDENT CHILD BECOME ELIGIBLE FOR COBRA CONTINUATION COVERAGE?

Your dependent children can elect COBRA continuation coverage upon the occurrence of any of the following events:

1. Your death.

2. Your dependent child's loss of coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout, or layoff.

3. Divorce or judicial order of legal separation of the child's parents.

4. Your enrollment in Part A or Part B of Medicare.

5. The child ceases to qualify as an "eligible dependent" as described in this SPD.

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.

HOW IS A PERSON ELIGIBLE FOR COBRA CONTINUATION COVERAGE NOTIFIED OF HIS OR HER ELIGIBILITY?

Your employer has the obligation to notify the Fund Office of your death, employment termination, reduction in hours leading to a loss of eligibility, or your enrollment in Part A or Part B of Medicare.

You have the responsibility to inform the Fund Office of a divorce, judicial order of legal separation, a child's loss of status as an eligible dependent, or the birth or adoption of a dependent. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to

give notice to the Fund Office within the time limits may result in your ineligibility for COBRA continuation coverage.

After the Fund Office receives notice of the occurrence of one of the above qualifying events, it will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Fund 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 coverages have terminated.

WHEN MUST THE ELECTION BE MADE?

The employee, spouse, and dependent children each has independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. 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, 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.

WHAT TYPE OF BENEFITS ARE AVAILABLE IN COBRA CONTINUATION COVERAGE?

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance or disability benefits or accidental death and dismemberment benefits or other non-health benefits will be included.

HOW LONG DOES COBRA CONTINUATION COVERAGE LAST?

If the election is due to termination of your employment or a reduction in hours worked, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, each of you can receive a total of 29 months of COBRA continuation coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. The employer no longer provides group health coverage.

2. Failure to pay the monthly premium on time.

3. 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.

4. The individual enrolls in Part A or Part B of Medicare.

5. Circumstances are such that the individual's participation could be canceled if the individual were an active employee.

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.

Under New York State Law, continuation coverage generally is available for up to 36 months following the loss of employer-sponsored coverage due to job loss. If federal COBRA coverage has been exhausted under an insured group health plan, qualified beneficiaries will have the opportunity to extend coverage under New York law for an additional 18-month period for up to a total of 36 months following the date federal COBRA continuation coverage began.

WHAT IS THE COST OF COBRA CONTINUATION COVERAGE AND HOW IS THE COST COMPUTED?

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the insurance company for the insured health benefits to continue COBRA continuation coverage. The monthly premium will generally be determined on an annual basis and will include 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 monthly premium.

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is described in greater detail in a letter sent out by the Fund Office to each participant when the participant becomes eligible to participate in the Fund. If you have any questions concerning COBRA continuation coverage, you should contact the Fund Manager.

There may also be alternative health insurance coverage options for you and your family other than purchasing COBRA coverage from this Plan. When key parts of the Patient Protection & Affordable Care Act took effect in 2014, you became able to buy coverage through the Health Insurance 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: HealthCare.gov. In considering whether coverage through the Marketplace is better for you than COBRA coverage, you could be eligible for a tax credit that lowers your monthly premiums right away. Information about the Marketplace can help you see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility coverage for a tax credit through the Marketplace. In addition to the options available from the Marketplace, you may qualify for a special enrollment opportunity to obtain coverage from another group health plan for which you are eligible (such as a spouse's Plan). Even if the other Plan generally does not accept late enrollees, you may still qualify if you request enrollment within 30 days. If you would like more information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence. For example, in New York State, the website for the Marketplace is: healthbenfitexchange.ny.gov.

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 U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website @ www.dol.gov/ebsa. (Addresses and telephone number of Regional and District EBSA Offices are available through EBSA's website).

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

PART E

TECHNICAL DETAILS

(As required by the Employee Retirement Income Security Act of 1974)

1. PLAN NAME: Upstate Union Health & Welfare Fund.

2. EDITION DATE: This Summary Plan Description is produced as of January 1, 2019.

3. PLAN SPONSOR: Board of Trustees of Upstate Union Health & Welfare Fund.

4. PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 16-6072836.

5. PLAN NUMBER: 501 (assigned by federal government).

6. TYPE OF PLAN: Welfare Plan.

7. PLAN YEAR ENDS: December 31st.

8. PLAN ADMINISTRATOR: Board of Trustees of Upstate Union Health & Welfare Fund.

9. AGENT FOR SERVICE OF LEGAL PROCESS: Fund Manager, Upstate Union Health & Welfare Fund.

   In addition to the above person designated as agent for legal process, service of legal process may also be made upon any Plan Trustee.

10. TYPE OF PLAN ADMINISTRATION AND PLAN FUNDING: The Plan is administered by the Board of Trustees and the benefits are insured except for Telemedicine visits which are self-insured.

11. SOURCES OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the Upstate Union Health & Welfare Fund.

12. COLLECTIVE BARGAINING AGREEMENTS: This Plan is maintained in accordance with collective bargaining agreements. A copy of an agreement may be obtained by you upon written request to the Fund Manager and is available for examination by you at the Plan Office.

13. PARTICIPATING EMPLOYERS: You may receive from the Fund Manager, upon written request, information as to whether a particular employer participates in the sponsorship of the Plan. If so, you may also request the employer's address.

14. PLAN BENEFITS PROVIDED BY: Upstate Union Health & Welfare Fund.

15. ELIGIBILITY REQUIREMENTS, BENEFITS & TERMINATION PROVISIONS OF THE PLAN: Described in the Introduction, Parts A and B of this SPD.

16. HOW TO FILE A CLAIM: Application for all self-insured benefits must be made by writing, telephoning, or visiting the Fund Office (during the hours of 8:30 A.M. to 4:30 P.M., on

regular business days). Application for insured benefits must be made in accordance with the applicable policy.

17. NO INSURANCE UNDER PBGC: Since this Plan is not a defined benefit pension Plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.

18. TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees of the Upstate Union Health & Welfare Fund.