AUTOMOTIVE INDUSTRIES WELFARE FUND

PLAN C

HEALTH PLAN ENROLLMENT GUIDE EFFECTIVE JANUARY 1, 2017

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Automotive Industries Welfare Fund
Administered By: Health Services & Benefit Administrators (HS&BA)
4160 Dublin Blvd., Suite 400 | Dublin, CA 94568
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www.aitrustfunds.org

HS&BA

At HS&BA, we can help you with:	HS&BA can be reached at
• Eligibility issues. • Enrollment and changes in provider. • COBRA information and applications. • Adding dependents or updating information.	Toll-Free (800) 635-3105 Fax (925) 588-7121

Member Services

If you have questions that are more plan specific, contact the provider directly.	• Questions about how much a procedure costs? • What is covered under my Medical/Dental Plan? • Where do I go to see a doctor? • Which dentist will accept my coverage? • Where do I go for an emergency? • I moved, I need to change my doctor or network.

Health Care Providers & Contact Information

Service Provider	Phone	Website
Anthem Blue Cross / Direct Pay	800-274-7767	www.anthem.com
Kaiser / Kaiser Rx	800-464-4000	www.kp.org
OptumRx	800-797-9791	www.optumRx.com

*If you are enrolled in Anthem Blue Cross, your Pharmacy Benefit Manager is Optum Rx

Dental Care & Orthodontia Providers & Contact Information

Service Provider	Phone	Website
BrightNow! Dental	800-497-6453	www.brightnow.com
Delta Dental of CA	866-499-3001	www.deltadentalofCA.com
First Dental Health	800-334-7244	www.firstdentalhealth.com
Orthodontia (Automotive Industries Welfare Fund)	800-635-3105	www.aitrustfunds.org
SafeGuard, a MetLife company	800-880-1800	www.metlife.com
United Concordia Plus	866-357-3304	www.unitedconcordia.com
United Healthcare Dental	800-999-3367	www.myuhc.com
Vision Service Plan	800-785-0699	www.vspdirect.com

ABOUT YOUR ENROLLMENT GUIDE

A Word from the Trustees…

With today's high health care prices, getting quality health care benefits at a reasonable cost is important — and challenging — to all of us. It means having good health plan choices, asking questions about treatment alternatives, and using our benefits wisely.

YOU ARE ONLY ELIGIBLE FOR BENEFITS WHICH HAVE BEEN NEGOTIATED BETWEEN YOUR EMPLOYER AND THE UNION

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WISE BUYING… THE KEY TO QUALITY HEALTH CARE AT A REASONABLE COST

In most cases, the Trust Fund pays for coverage you select using contributions from participating employers. As health care costs continue to rise, it becomes more and more important to be careful buyers of medical care. We encourage you to:

- *Take time to learn about your options and how the plans can work best for you.*
- *Question your doctors and dentists so you'll better understand your health care alternatives.*

With your informed, thoughtful purchase of services, we hope to maintain quality benefits at a cost we can all afford.

Board of Trustees
Automotive Industries Welfare Fund

The Trust Fund designed this Enrollment Guide to help you review your health care needs and pick the best plans for you and your family. The Guide is a summary of the information from the Automotive Industries Welfare Fund Summary Plan Description, Rules and Regulations, and Kaiser material which govern plan benefits. If any conflict arises between this Guide and the SPD, Rules and Regulations, or Kaiser materials, the SPD, Rules and Regulations, or HMO literature will govern this plan's administration and benefit payment.

If you want more information contact the Trust Fund Office at (800) 635-3105. You can also write the Fund at 4160 Dublin Blvd., Suite 400, Dublin, CA 94568. While the Trustees intend to continue this plan indefinitely, they reserve the right to interpret eligibility or plan provisions, and to change or terminate the plan at any time.

MEETING YOUR MEDICAL NEEDS

You are eligible for **Plan C Medical** if your employer has negotiated Plan C medical benefits with your union. The Automotive Industries Welfare Fund's variety of medical plans protects you and your dependents against the high cost of treating major illness or injury, and gives you choices about how to receive your care:

- **Kaiser HMO.** You must receive all your care through a Kaiser hospital or physician. You are encouraged to select a Primary Care Physician (PCP). Expenses incurred from a non-Kaiser provider will only be covered for emergency services. You must live or work within the Kaiser service area to enroll.

  There is a calendar year deductible of $1,000 per person ($2,000 per family). This is the amount you must pay in a calendar year before Kaiser provides most covered services. Some services, including most preventative care, are not subject to the deductible. Then, you must pay a portion of the charges when receiving covered services. For some services, you must pay a copayment of $10-$20. For some other services, you must pay a 20% coinsurance and the Kaiser plan would pay 80%. Your coinsurance and copayment do not apply toward your deductible, but do count toward your annual out-of-pocket maximum.

  The annual out-of-pocket maximum is the maximum amount you will pay for certain covered services in a calendar year. Once you have reached that maximum, you won't have to pay any deductible, copays, or coinsurance for most covered services for the rest of the calendar year.

- **Direct Pay Medical Plan**. On the Direct Pay Plan, unlike Kaiser, medically necessary care from any licensed provider that you select will be covered according to Plan rules. The Plan has arrangements with Anthem Blue Cross under which various Hospitals, laboratories, physicians and specialists agree to provide care to you at negotiated Preferred Provider Organization (PPO) rates. You will have less out-of-pocket expense when an Anthem Blue Cross PPO hospital, laboratory, physician, or specialist is used. In California, the Anthem Blue Cross network is called "Prudent Buyer."

  In all other states, the PPO is provided through the National Blue Cross /Blue Shield Association. For provider listings go to:

  California: www.bluecrossca.com
  All other states: www.bluecares.com

  You must pay the first $1,000 per person ($2,000 for family) in medical expenses every year. You must then pay a portion of covered expenses. In general, the plan will pay 85% of contracted rates for a PPO provider and 65% of allowed charges for a provider not contracted with Anthem Blue Cross or the National Blue Cross/Blue Shield Association. After you or your family have incurred $2,000 for single participant or $4,000 for a family in allowed charges billed by PPO providers in a calendar year, the Plan will pay 100% of allowed charges for the remainder to that calendar year. (*Note: The 100% coinsurance provision does not apply to charges billed by non-PPO providers)*.

  You also receive greater benefits when you have an elective hospital stay pre-certified by Anthem Blue Cross before you are admitted (and within 48 hours for emergency admissions). The toll-free number for California and all other states is (800) 274-7767.

ANTHEM BLUE CROSS LIVEHEALTH ONLINE SERVICES

You can use a smart phone, tablet or computer to have a live video visit with a board certified doctor affiliated with the Anthem Blue Cross LiveHealth Online Service to discuss non-emergency health issues from home, work or wherever you happen to be as long as you have Internet access. You can use this service to communicate with a doctor about colds, aches, sore throats, allergies, infections as well as wellness and nutrition advice. Your copayment is a $20 (deductible waived). To access this program, you can sign up at www.livehealthonline.com.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Available funds from your Health Reimbursement Account (HRA) can be used to pay your deductible, copayment and coinsurance amounts for eligible medical, prescription drug, dental and vision expenses.

- Your employer will provide funding for your HRA. The amount of the funding is based on the Agreement between your employer and the Union – it may be $500/$750/$1,000 per year for a single person (twice the amount for a family)
- A card will be sent to your home address allowing you to use the benefit. The card functions just like a debit card and is accepted at the vast majority of service providers' offices and pharmacies.
- The HRA amount will be contributed to the account whether you enroll in Kaiser or the Direct Pay Plan.
- Once the HRA contribution amount is exhausted in a calendar year, expenses are paid by you or your dependent until the out-of-pocket maximum is satisfied.
- Unused HRA amounts will not roll over from year to year. Each January when your deductible and out-of-pocket maximums are reset, your HRA funding will reset as well to the amount agreed on by the employer and Union.
- You are permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, in a time and manner determined by the Fund Office. Upon your termination of employment, you may opt out and waive future reimbursements from the HRA.
- The HRA only covers medical expenses, prescription drugs, dental, vision and certain IRS approved over-the-counter supplies and medications. A list of approved over-the-counter items can be found on the IRS's website.
- If your eligibility terminates and you have remaining credits in your HRA account, those amounts will be forfeited at the end of the month of termination. The only exception to this procedure is if you elect COBRA Continuation Coverage.

AFFORDABLE DRUG COVERAGE

Your prescription drug coverage will depend on the plan you are enrolled in.

- **Kaiser Enrollees:** If you are enrolled in Kaiser, you must obtain your drugs at Kaiser Permanente pharmacies. Generic drugs are available with a $10 copayment and brand name drugs with a $30 copayment for a 30-day supply.
- **Direct Pay Medical Plan Enrollees:** These enrollees receive prescription drugs from the Trust Fund. You must use an OptumRx pharmacy. If you fill or refill prescriptions at a retail pharmacy, you will pay 20% of the charge plus $5 for up to a 30-day supply per formulary generic prescription or 20% of the charge per formulary brand name prescription or 20% of the charge plus $15 per non-formulary brand name prescription. The copayment is capped at $100 for certain formulary/non-formulary brand name prescriptions at retail. For mail order, prescriptions are covered in full after a $40 copayment for formulary generic drugs and a $60 copayment for brand name drugs, regardless of whether the drug is on the formulary, for a 90-day supply. The out-of-pocket limit for individual is $2,000 ($4,000 per family).

A VARIETY OF DENTAL OPTIONS

If your employer has negotiated for dental benefits with your union, dental coverage is available to you and your eligible dependents. Each of your dental care choices covers preventive, basic, and major care. Benefits depend on the plan in which you enroll. New dental eligibles cannot enroll in Delta Dental or the Scheduled Direct Pay Plan for the first 12 months of coverage. Therefore, during their first 12 months of coverage, they are limited to enroll in one of the DMOs shown below. Dental Plan Options include:

- **Dental Maintenance Organization (DMO):** The Bright Now!/Newport Dental, MetLife, United Healthcare Dental and United Concordia Dental Plans operate like HMOs, providing services only through participating dental offices. You will be responsible for small copayments for most covered services.
- **Delta Dental Plan:** Like the Direct Pay Medical Plan, the Delta Dental plan allows you to use any licensed dentist, but pays a higher benefit when you use Delta Preferred Option Dentists. For most participants, there is a $3,000 annual maximum benefit and you pay 20% of covered expenses when you use a Delta Preferred Option Dentist (30% of covered expenses when you do not). The maximum does not apply to pediatric dental services.
- **Scheduled Direct Pay Dental Plan:** The Scheduled Dental Plan also allows you to use any licensed dentist of your choice. The Plan pays 100% of a scheduled amount for covered dental treatment, not to exceed a $2,500 annual maximum per eligible person. The maximum does not apply to pediatric dental services. However, the Plan offers members access to a dental PPO network, First Dental Health (FDH). FDH providers offer members treatment at discounted rates. Therefore, your annual maximum benefit goes farther by using a FDH dentist. For information on locating a FDH dentist, please contact FDH at (800) 334-7244 or www.firstdentalhealth.com

ORTHODONTICS

If your employer has negotiated for self-funded orthodontic benefits with your union, Orthodontic coverage is available to you and your eligible dependents once you have been covered by the Plan for three months. If you are eligible for orthodontic coverage, orthodontic treatment will be covered in full up to a lifetime benefit of $2,500 per individual. If you enroll in a Dental Maintenance Organization, orthodontia may be available at discounted rates if you use a panel orthodontist. Regardless which dental plan option you have selected, orthodontic benefits are paid by the Fund Office once a claim is filed by your orthodontist.

VISION CARE

If your employer has negotiated vision benefits with your union, whichever medical plan you choose, you may use VSP's network of eye care professionals to receive exams, and purchase lenses and frames. Kaiser also offers eye exams.

DISABILITY INSURANCE

If your employer has negotiated self-funded disability benefits with your union, you may be eligible for disability payment on the first work day following a hospital confinement or disability due to an accident. Disability payment will commence on the fourth work day following a disability due to an illness. During any one disability period, as defined by the Plan, disability benefits are provided up to a maximum of 195 days (39 weeks).

BURIAL BENEFIT

If you are entitled to medical coverage through the Fund, you are automatically entitled to the Burial Benefit. This benefit provides payment of $2,500 to your designated beneficiary upon the death of a covered Participant. Burial benefits are available to Active Employees and his or her covered Dependents.

LIFE INSURANCE

If you are covered for Life Insurance, the amount available upon the death of you or your eligible dependents is dependent on your employer's collective bargaining agreement with your union.

ELIGIBILITY AND ENROLLMENT - WHO IS ELIGIBLE

- **Contract Employees and Owners who work with the tools of the trade (Class 1):** Employees working under a bargaining agreement between an employer and a participating union, as well as employees of a participating union or administrative office. Owners who work with the tools of the trade and have a bargaining agreement with a participating union shall be treated as a Class 1 employee and subject to all the rules applicable for Class 1 employees.

- **Non-Contract Employees (Class 2):** Employees not working under a bargaining agreement, who work at their employer's principle place of business and who receive compensation for work an average of 30 hours per week (or 130 hours per month).

- **Dependents:** If YOU qualify for benefits, the following dependents are covered at no charge to you:

  – Your legal spouse or domestic partner (as defined by the Plan);

  – A Dependent Child is anyone who has one of the relationships with the Employee listed below, who are under the age of 26 (whether married or unmarried): natural children, stepchildren, legally adopted children and a child named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO) who are less than 26 years of age (21 for life insurance). In addition, children of an eligible Domestic Partner, children for which you have been made the legally appointed guardian who is less than 26 years of age (21 for life insurance). Lastly, disabled children who are age 26 years or older, continue to be eligible for coverage regardless of age if they are incapable of self-supporting employment because of a mental or physical disability that was present prior to age 26 and are declared by the Employee as their dependent for Federal Income Tax purposes (but only to age 21 for life insurance).

  Please note that the Plan will request Birth Certificates, Marriage Certificates and any other relevant documentation at the time of initial enrollment or when additions are made.

- **Ineligible Dependents:** A spouse of a Dependent Child (e.g. son-in-law/daughter-in-law) or child of a Dependent Child (e.g. Employee's grandchild) are not eligible for coverage under the Plan.

- **Class 1 and Class 2 Employees** may select either the Direct Pay Plan or, for those who reside within Kaiser the service area, the Kaiser HMO.

- All new hires must enroll in one of the Dental DMOs for the first 12 months after they become eligible.

If you have any questions, contact the Trust Fund Office at (800) 635-3105.

WHEN COVERAGE STARTS

Coverage will start the first day of the month following the date your active employment begins. However, if your employer qualifies for participation under this plan after the date your employment begins, coverage will begin under the plan on the qualification date.

Exceptions:

- **Contracting Employees:**
  If the collective bargaining agreement specifies a different eligibility date for employees (i.e. Probationary Period), then eligibility shall commence as specified in that agreement.
- **Non-contract Employees:**
  If your employer has a collective bargaining agreement under which coverage is provided to contract employees, the commencement date for a non-contract employee shall be no earlier than the commencement date for a contract employee with the same employment date.

Coverage for your dependents will begin on the same date as yours, or the date they meet the definition of a dependent, if later.

CHOOSING A MEDICAL PLAN

An eligible member may change his or her medical or dental plan option once in a 12-month period. There is no specific open enrollment period. Instead, eligible participants will have the opportunity to change plan(s) anytime during the year. However, participants must be eligible for health plan coverage and remain in the plan selected for a minimum of 12 consecutive months, unless the participant moves out of the HMO/DMO plan's service area. Any change in plan(s) will be effective on the first day of the month following the date the enrollment form is received by the Trust Fund Office.

Newly eligible employees may select either the Direct Pay Plan or Kaiser.

When a change is made, an anniversary date for that medical or dental provider is established. This anniversary date will be used to determine when future changes may be allowed.

Please remember that your dependents will be enrolled in the same plan as you.

Plan Enrollment Note:

You will remain enrolled in your current medical/dental plan until you notify the Trust Fund Office a desired change and submit an enrollment form for the new Plan in which you wish to be enrolled.

OPT-OUT

- You may opt back into coverage due to a HIPAA special enrollment event (please see section in this Guide). This would include certain events such as divorce, birth of a child and loss of other Group Health Coverage, if the Trust Fund Office is notified of the change within 31 days. Coverage under an opt-in request will begin the first of the month following 31 days after receipt of a completed opt-in form.
- You are only eligible for benefits which have been negotiated between your employer and the union. You may opt out of all negotiated benefits or some of them. Should you wish to opt out, the following are your options if your employer has negotiated with your union:
  - Option 1: opt out all benefits.
  - Option 2: opt out medical and prescription drug; retain vision, dental, orthodontic, life and disability benefits.
  - Option 3: opt out vision, dental, orthodontic, life and disability; retain medical and prescription drug.
  - Any member eligible for dental benefits may notify the Fund Office if they do not want to receive those benefits.

As you review your medical options, please look at:

- **Doctor relationships - Consider the following**:
  - If your current provider is not already a Kaiser doctor or an Anthem Blue Cross PPO provider, consider whether you have one close to home or work and whether you would be willing to change doctors.
  - Whether you or a family member has treatment in progress. You may not want to move to a plan that limits benefits for treatment you are currently receiving.
- **Freedom of choice:** The Direct Pay Plan offers more freedom, letting you use any doctor or hospital. If you use Blue Cross PPO hospitals, laboratories, physicians or specialists, you will benefit from lower out-of-pocket costs.
- **Services:** Each plan provides slightly different benefits and limits on some types of medical care. Use this Guide's plan comparisons and more detailed plan literature available from the Trust Fund Office to make sure you are enrolling in a plan that meets your family needs.
- **Out-of-area care:** If you have a child away at school or you often travel away from home or work, note that Kaiser only provides emergency care outside their service area.
- **Convenience of facilities**: Look at where the Kaiser or the PPO medical facilities, hospitals and participating pharmacies are located in relation to your home and work.
- **Plans for retiring:** The CMTA-IAM Joint Retiree Health and Welfare Trust offers medical coverage options to eligible retirees (please refer to the CMTA-IAM Joint Retiree Health and Welfare Trust Enrollment Guide*).*

WHEN COVERAGE ENDS

Your coverage ends on the later of:

- The date on which your employer ceases to make payments for your benefits,
- The date on which you lose continuation coverage offered through COBRA. Refer to pages 19-23 for the general Notice of Automotive Industries Welfare Fund Continuation of Coverage Rights under COBRA.

ABOUT YOUR MEDICAL AND DENTAL PLAN COMPARISONS

Use the following charts to compare the Automotive Industries Welfare Fund medical and dental options and pick the plans best suited for you. The charts summarize major plan provisions, while the Summary Plan Descriptions, Kaiser contract and the Rules and Regulations present benefits in more detail. If any conflict arises between this Guide and the SPD, the Kaiser contract or the contracts with the DMO plans or Rules and Regulations, the SPD, contracts and Rules and Regulations will govern plan administration and benefit payment. Contact the Trust Fund Office to request booklets for the plans in which you are most interested.

PLAN C - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	DIRECT PAY (with Anthem Blue Cross PPO)	KAISER PERMANENTE
Group Number **Member Services Telephone Numbers**	Anthem Blue Cross PPO Network & Review Organization: (800) 274-7767 Claims: (800) 635-3105, Option 2	Group 57-2 (800) 464-4000 www.kp.org
Type of Plan	Self-insured plan provides traditional medical benefits. Members may seek care from any covered licensed provider of their choice. Special arrangements offer higher benefits and discounted rates when medical treatment is performed by a California Anthem Blue Cross providers or National Blue Cross/Blue Shield Association outside California.	Health Maintenance Organization (HMO) with benefits in the form of services received from Kaiser Permanente staff at Kaiser Permanente Hospitals and medical offices.
Geographic Area	No service area requirements apply.	Kaiser Permanente provides service in all or part of the following counties: Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Sutter, Santa Clara, Solano, Sonoma, Stanislaus, Tulare, Yolo and Yuba Counties.
Choice of Providers	Unlimited choice of providers. However, you save money by using a PPO Hospital, Laboratory, Physician, or Specialist.	Use Kaiser Permanente hospitals and physicians. You are encouraged to select a personal Kaiser Permanente physician.
Specialized Care *In-Network*	85% of PPO contracted rates	100% after $20/visit if Kaiser Permanente physician refers you to outside specialist
Outside Network	65% of allowed (Usual, Customary & Reasonable) charges	
Percentage Payable	PPO Provider: 85% of contracted rates Non-PPO Provider: 65% of allowed charges	80% after applicable copayment amount
Out-of-Area Care	85% of allowed charges when there is no PPO Provider within 30 miles from your home or workplace. This also applies to emergency * care, ambulance and certain other services.	Worldwide emergency coverage for unforeseen illness or injury.
Claims	File claims with the Automotive Industries Welfare Fund.	No claim forms except for out-of-plan emergency care from non-Kaiser Permanente providers.

* "Emergency" is defined in the Plan Booklet.

PLAN C - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	DIRECT PAY (with Anthem Blue Cross PPO)	KAISER PERMANENTE
Medical Plan Calendar Year Deductible (medical, mental health and substance abuse) *Per Person* *Per Family*	Deductible does accumulates towards out-of-pocket maximum $1,000 $2,000	Deductible does accumulates towards out-of-pocket maximum $1,000 $2,000
Health Reimbursement Account (HRA)	Funding level may be $500, $750 or $1,000 per year (twice for family), depending on what has been negotiated between your employer and the union.	Funding level may be $500, $750 or $1,000 per year (twice for family), depending on what has been negotiated between your employer and the union.
Medical Plan Out-of-pocket Calendar Year Limit **(maximum will accumulate all medical, and mental health and substance abuse)**	The Out-of-Pocket Limit for cost-sharing for in-network PPO copayments, coinsurance and deductibles (and non-PPO emergency room for an emergency) are as follows: Single: $2,000 Family: $4,000 No Out-of-Pocket limit for cost-sharing for Non-PPO providers. In-Area Non-PPO is not subject to the $30,000 calendar year allowable charge maximum.	The Out-of-Pocket Limit for cost-sharing for in-network copayments, coinsurance and deductible as follows: Single - $2,000 Family - $4,000
Hospital *Inpatient*	**PPO Hospital**: 85% of contracted rates* **Non-PPO Hospital**: 65% of allowed charges *	80% after deductible
Outpatient Surgery	**PPO Hospital**: 85% of contracted rates **Non-PPO Hospital**: 65% of allowed charges	80% after deductible
Emergency Services **	**PPO Hospital**: 85% of contracted rates **Non-PPO Hospital**: allowance is the greater of: the negotiated amount for in-network providers, or 100% of the plan's Allowed Charge formula (reduced for cost-sharing) or the amount that Medicare would pay	80% after deductible

* Benefits are reduced by $250 if preauthorization is not obtained from Blue Cross. See booklet for Direct Pay Schedule of Health Benefits.

** "Emergency" is defined in the Plan Booklet.

PLAN C - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	DIRECT PAY (with Anthem Blue Cross PPO)	KAISER PERMANENTE
Home Health Care	Limited to 150 visits per calendar year **PPO Provider**: 85% of contracted rates **Non-PPO Provider**: 65% of allowed charges	100% (when authorized by Plan Physician and Committee) for part-time intermittent care. Maximum 100 visits per calendar year as prescribed by a Kaiser physician.
Hospice Care	**PPO Provider**: 85% of contracted rates **Non-PPO Provider**: 65% of allowed charges	Provided at no charge if a Kaiser physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less.
Diagnostic X-Ray and Lab	**PPO Provider**: 85% of contracted rates **Non-PPO Provider**: 65% of allowed charges	$10 copayment after deductible except specialized radiological procedures (CT, MRI, PET) are covered at $50/procedure after deductible. Preventive x-rays, screenings, and laboratory tests are no charge (deductible does not apply)
Allergy *Testing*	**PPO Provider**: 85% of contracted rate **Non-PPO Provider**: 65% allowed charges	$20 per visit after deductible
Injection	**PPO Provider**: 85% of contracted rate **Non-PPO Provider**: 65% of allowed charges	No charge after deductible
Physical Therapy (*Outpatient)*	Limited to 12 visits per calendar year (24 visits per calendar year if therapy is provided in connection with a related surgical procedure performed within 24 months of the therapy). **PPO Provider**: 85% of contracted rates. **Non-PPO Provider**: 65% of allowed charges	$20 per visit after deductible
Physician Fees *Surgery*	**PPO Provider**: 85% of contracted rates **Non-PPO Provider**: 65% of allowed charges	80% after deductible
Office Visits/Consultation	**PPO Provider**: 85% of contracted rates **Non-PPO Provider**: 65% of allowed charges	$20 per visit after deductible
Hospital Admission Visit/ *Hospital Follow-Up Visit*	**PPO Provider**: 85% of contracted rates **Non-PPO Provider**: 65% of allowed charges	80% after deductible

PLAN C - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	DIRECT PAY (with Anthem Blue Cross PPO)	KAISER PERMANENTE
Skilled Nursing Facility Care	Limited to 120 days per disability **PPO Provider**: 85% of contracted rates **Non-PPO Provider**: 65% of allowed charges	80% after deductible up to 100 days per benefit period
Preventive Care for Men	**PPO** preventive care that is required to be covered under Health Care Reform will be payable at 100%, no deductible. **Non-PPO Provider**: Not covered except colonoscopies and sigmoidoscopies. If a colonoscopy or sigmoidoscopy is performed at a Non-PPO facility and/or by a Non-PPO Physician, the Fund will reimburse at the Non-PPO Allowance.	100%; no deductible
Preventive Care for Women (including Contraception)	**PPO Provider**: preventive care that is required to be covered under Health Care Reform will be payable at 100%, no deductible. **Non-PPO Provider**: Not covered except colonoscopies and sigmoidoscopies. If a colonoscopy or sigmoidoscopy is performed at a Non-PPO facility and/or by a Non-PPO Physician, the Fund will reimburse at the Non-PPO Allowance.	100%; no deductible
Preventive Care for Dependent Child	**PPO** preventive care that is required to be covered under Health Care Reform will be payable at 100%, no deductible. Preventive care with a **non-PPO provider** will not be covered.	100%; no deductible
Maternity Care *Pre-Natal Care*	**PPO provider**: 100% of contracted rate. **Non-PPO provider**: 65% of allowed charges	100% (Scheduled prenatal care exams and first postpartum follow-up consultation and exam are no charge)
Delivery/Inpatient Hospital Services (Benefits for a Mother's PPO Inpatient Hospital Services include charges for newborn nursery care)	**PPO provider**: 85% of contracted rate. **Non-PPO provider**: 65% of allowed charges	80% after deductible

PLAN C - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	DIRECT PAY (with Anthem Blue Cross PPO)	KAISER PERMANENTE
Other Services *Ambulance*	**PPO provider**: 85% of contracted rates. **Non-PPO provider**: 85% of allowed charges	$150 per trip after deductible when medically necessary and authorized by Plan physician. Air ambulance must be arranged for in advance by health plan.
Infertility Services	Not Covered	50% (In-vitro fertilization is not covered) *
Voluntary Sterilization	**PPO provider**: 100% for care required to be covered under Health Care Reform. No deductible. **Non-PPO provider**: 65% of allowed charges (Limited to Employee and Spouse)	100%
Durable Medical Equipment	**PPO provider**: 85% of contracted rates. **Non-PPO provider**: 65% of allowed charges	80% when prescribed by Health Plan physician. Some limitations and exclusions apply. *
Prosthetic/Orthopedic Appliances	**PPO provider**: 85% of contracted rates. **Non-PPO provider**: 65% of allowed charges	100% when prescribed by Health Plan Physician. Some limitations and exclusions apply.
Chiropractic Care	Covered up to 12 visits per calendar year. **PPO provider**: 85% of contracted rates. **Non-PPO provider**: 65% of allowed charges	Not Covered
Vision Care	Not covered under the Medical Plan. Vision Care benefits through VSP are available to employees of certain participating employers. Frequency – exam, lenses and glasses (or contact lenses) are available every 24 months Exam and Materials - $25 total copayment Frames - $130 allowance Contact Lenses – up to $60 copay; $130 allowance Diabetic Eyecare Plus Program - $20 copayment	100% eye exams for refraction. Vision Care benefits through VSP are available to employees of certain participating employers. Frequency – exam, lenses and glasses (or contact lenses) are available every 24 months Exam and Materials - $25 total copayment Frames - $130 allowance Contact Lenses – up to $60 copay; $130 allowance Diabetic Eyecare Plus Program - $20 copayment
Hearing Care	Not covered, except hearing aids are covered for dependent children. Covered charges for hearing aids are paid in full up to $400 per 36-month period (Calendar year deductible and coinsurance does not apply). Cochlear implants are covered for children born with a hearing deficit.	100% for exams only

* Benefits do not accumulate to the out-of-pocket maximum.

PLAN C – BEHAVIORAL HEALTH PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	DIRECT PAY (with Anthem Blue Cross PPO)	KAISER PERMANENTE
Alcohol and Substance Abuse *Inpatient*	This coverage is provided by Anthem Blue Cross. **PPO provider**: 85% of contracted rates. **Non-PPO provider**: 65% of allowed charges	This coverage is provided by Kaiser. 80% after deductible
Outpatient	**PPO provider**: 85% of contracted rates. **Non-PPO provider**: 65% of allowed charges	$20 individual visit / $5 group visit after deductible
Mental Health *Inpatient*	This coverage is provided by Anthem Blue Cross. **PPO provider**: 85% of contracted rates. **Non-PPO provider**: 65% of allowed charges	This coverage is provided by Kaiser. 80% after deductible; unlimited on the days
Outpatient	**PPO provider**: 85% of contracted rates. **Non-PPO provider**: 65% of allowed charges	$20 per individual visit or $10 per group visit after deductible
Preauthorization for Alcohol and Substance Abuse and Mental Health	Inpatient admission requires preauthorization. Failure to obtain preauthorization for an inpatient confinement may result in a $250 benefit reduction or denial of services if services are deemed not medically necessary. Please contact Anthem prior to receiving outpatient care in order to be directed to a PPO provider.	Preauthorization is required for all Kaiser treatment, except for emergencies.
Member Assistance Program (MAP) Employee only. Dependents are not eligible for MAP benefits**.**	This coverage is provided by MHN 1-3 sessions. $0 copay, 24-hour, toll-free access (legal, financial, elder care, childcare services & identity theft prevention assistance). Website: www.members.mhn.com Access Code: aiwfmap	This coverage is provided by MHN 1-3 sessions. $0 copay, 24-hour, toll-free access (legal, financial, elder care, childcare services & identity theft prevention assistance). Website: www.members.mhn.com Access Code: aiwfmap

PLAN C – PRESCRIPTION DRUG PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	DIRECT PAY (with Anthem Blue Cross PPO)	KAISER PERMANENTE
Outpatient Prescription Drug	This coverage is provided through OptumRx Benefits are available under the Direct Pay Prescription Drug Program. You must use an OptumRx pharmacy for Retail and Mail Order. **Mandatory Generic -** If you choose a brand name drug when a generic equivalent is available, you must pay the full price for that brand name drug. Female Contraceptive: No copay or deductible for generic contraceptives (or brand if generic is medical inappropriate). **Preventive Care Drugs -** No copay or deductible for preventive care drugs required under Health Care Reform. This includes FDA approved tobacco cessation products (both prescription and over the counter medications) for a 90-day treatment regimen (two cycles).	This coverage is provided through Kaiser Deductible does not apply. The prescription drug copayments do not accumulate to the deductible.
Out-of-Pocket Calendar Year Maximum	Single: $2,000 Family: $4,000	Prescription drug out-of-pocket copayments accrue toward to medical out-of-pocket.
Deductible	None	None
Retail Pharmacy	Formulary Generic: 20% plus $5 copay Formulary Brand: 20% * Non-formulary: 20% plus $15 copay * Day supply: 30 days * Maximum co-payment of $100 per brand name prescription if the brand name drug is unavailable as generic and unavailable through mail order. Also, $100 maximum co-payment for injectables.	Generic: $10 copay Brand Name: $30 copay Day supply: 30 days
Mail Order	Formulary generic drugs: 100% after $40 Brand-name drugs: 100% after $60, regardless of whether the drug is on the formulary. Day supply: 90 days	Mail delivery from a Kaiser Permanente pharmacy available for refill prescriptions only. Generic: $20 copay Brand Name: $60 copay Day supply: 100 days

PLAN C - DENTAL PLAN COMPARISON FOR ACTIVE EMPLOYEES						
GENERAL INFORMATION	SCHEDULED DIRECT PAY DENTAL PLAN	DELTA DENTAL PREFERRED PLAN *	NEWPORT DENTAL	METLIFE COMPANY	UNITED CONCORDIA PLUS	UNITED HEALTHCARE DENTAL
Group Number **Member Services Telephone**	Automotive Industries Claims: (800) 635-3105 FDH: (800) 334-7244	Group No. 2824 (800) 765-6003	Group No. NP8001 (800) 497-6453	Group No. 142616 (800) 942-0854	Group No. 740306 (866) 357-3304	Group No. 711992 PVRC 0001 (800) 999-3367
Type of Plan/ Choice of Providers	This is a Self-Funded Dental Plan that pays 100% of a dental schedule approved by the Fund or First Dental Health (FDH)'s contract rate, whichever is less. You may select any licensed dentist to provide your dental care. However, you save money by using the Plan's PPO provider network known as FDH.	This is a Dental PPO plan. You may select any approved dentist to provide dental care. However, you may save money by using the Plan's PPO provider known as Delta Dental.	This is a Dental HMO plan. You must use a Newport dentist for all your care. Your primary dentist refers you to a Newport Specialist when necessary. The office network includes 21 locations including the 17 Northern California Newport/Bright Now! Dental offices.	This is a Dental HMO plan. You must use a "Managed Dental Plan" provider for all your dental care. You select a dental office in the MetLife DHMO network for you and your family. Each family member may choose their own dental office from the MetLife DHMO network. Your MetLife General Dentist will directly refer patients to Specialists when necessary.	This is a Dental HMO plan. You must use a United Concordia Plus dentist for all your care. Each family member may choose their own dental office from the DHMO Concordia Plus General Dentist network. Your primary dentist refers you to a United Concordia participating specialist when necessary.	This is a Dental HMO plan. You must use a UnitedHealthCare Dental office for all your care; .however you do not need to assigned to an office. You select a dental office in the UnitedHealthCare Dental network for you and your family. Each family member may choose their own dental office from the United HealthCare Dental network
Out-of-Area	Not applicable	Provide all covered benefits at the lower coinsurance	Provides 24-hour emergency telephone access. With pre-approval, the Plan covers up to $50 for the relief of pain.	Emergency services that are rendered 50 miles from you or your dependent's selected general dentist, will receive coverage for the treatment up to a maximum of $50.	Plan pays $100 maximum for emergency care each 12-month period.	Plan pays $100 maximum for emergency care.
Claim Forms Required	Yes	No	No	No	No	No

* Dental benefits available under certain bargaining agreements may vary from those shown.

PLAN C - DENTAL PLAN COMPARISON FOR ACTIVE EMPLOYEES						
GENERAL INFORMATION	SCHEDULED DIRECT PAY DENTAL PLAN	DELTA DENTAL PREFERRED PLAN*	NEWPORT DENTAL	METLIFE COMPANY	UNITED CONCORDIA PLUS	UNITED HEALTHCARE DENTAL
HOW THE PLAN WORKS						
Yearly Maximum	$2,500 (does not apply to pediatric dental services)	$3,000 (does not apply to pediatric dental services)	None for Primary Dentists. $1,500 for Specialist referrals.	None	None	None
Benefits Payable	100% of scheduled or PPO contracted amounts. You must pay any charges over the scheduled amount if services are not performed by FDH PPO provider.	Delta Preferred Dentist - 80% of covered expenses Non-Delta Preferred Dentist - 70% of covered expenses	100% for most covered services. See Benefit Summary for details.	100% for most covered services. See Benefit Summary for details.	100% for most covered services. See Benefit Summary for details.	100% for most covered services. See Benefit Summary for details.
Diagnostic and Preventative Services	100% of scheduled amounts. You must pay any charges over the scheduled amount.	Delta Preferred Dentist - 80% of covered expenses** Non-Delta Preferred Dentist - 70% of covered expenses **				
Routine Oral Examination	100% of scheduled amounts. No frequency limitations.	Limited to two every 12 consecutive months	100%; two every 12 consecutive months	100%; no frequency limitations	100%	100%
Full Mouth X-Rays	100% of scheduled amounts. No frequency limitations.	Once every 36 months for full mouth and panoramic x-rays	100%; once every 36 months	100%; no frequency limitations	100%; once every three years	100%; once every 24 months
Prophylaxis: all participants	100% of scheduled amounts. No frequency limitations	Limited to two per calendar year	100%; two every 12 consecutive months	100%; two every 12 consecutive months	100%; one every 6 consecutive months	100%; one every 6 consecutive months

* Dental benefits available under certain bargaining agreements may vary from those shown.

** You must receive a diagnostic/preventive service in one calendar year in order to receive a copayment decrease of 10% for diagnostic/preventive services for the following year. That means the Plan will pay higher coinsurance for your coverage and your out-of-pocket cost is lower. As long as you receive a diagnostic/preventive service each calendar year, your copayment will be decreased 10% each year. If, during any calendar year, you do not receive a diagnostic/preventive service, the copayment for the following year will reduce by 10%. In addition, if during any year, you have a break in coverage of at least one month, the copayment for the following year will reduce to the base level (20% PPO/ 30% non-PPO).

PLAN C - DENTAL PLAN COMPARISON FOR ACTIVE EMPLOYEES						
GENERAL INFORMATION	SCHEDULED DIRECT PAY DENTAL PLAN	DELTA DENTAL PREFERRED PLAN *	NEWPORT DENTAL	METLIFE COMPANY	UNITED CONCORDIA PLUS	UNITED HEALTHCARE DENTAL
Basic Services *Fillings (Amalgams or Composites)*	100% of scheduled amounts. You must pay any charges over the scheduled amount.	Delta Preferred Dentist - 80% of covered expenses Non-Delta Preferred Dentist - 70% of covered expenses	100%	100%	100%, except resin fillings on posterior teeth have an $85 - $150 copayment.	100%
Major Restorations *Single Crown*	100% of scheduled amounts. You must pay any charges over the scheduled amount. Replaceable every 36 months, some exceptions apply.	Delta Preferred Dentist - 80% of covered expenses Non-Delta Preferred Dentist - 70% of covered expenses Some limitations apply.	100% Some limitations apply.	100% Some limitations apply.	100% Some limitations apply. Charges for the use of precious (high noble) or semi-precious (noble) metal are not included in the copayment.	100% Some limitations apply.
Endodontics *Root Canal*	100% of scheduled amounts. You must pay any charges over the scheduled amount.	Delta Preferred Dentist - 80% of covered expenses Non-Delta Preferred Dentist - 70% of covered expenses Some limitations apply.	100%	100% Some limitations apply.	100%	100%
Periodontics *Services treating teeth affected by diseased gingiva (gums).*	100% of scheduled amounts. You must pay any charges over the scheduled amount.	Delta Preferred Dentist - 80% of covered expenses Non-Delta Preferred Dentist - 70% of covered expenses	100%	100%	100% except $92-$120 copay for bone replacement grafts and $43 copay for localized delivery of antimicrobial agents, per tooth	100%

* Dental benefits available under certain bargaining agreements may vary from those shown.

PLAN C - DENTAL PLAN COMPARISON FOR ACTIVE EMPLOYEES						
GENERAL INFORMATION	SCHEDULED DIRECT PAY DENTAL PLAN	DELTA DENTAL PREFERRED PLAN *	NEWPORT DENTAL	METLIFE COMPANY	UNITED CONCORDIA PLUS	UNITED HEALTHCARE DENTAL
Prosthodontics *Bridges, partial dentures and full dentures*	100% of scheduled amounts. Replaceable every 36 months, some exceptions apply. You must pay any charges over the scheduled amount. Benefits are available once eligible for 3 consecutive months.	Delta Preferred Dentist - 80% of covered expenses Non-Delta Preferred Dentist - 70% of covered expenses Some limitations apply.	100% Some limitations apply.	100% Some limitations apply.	100% Some limitations apply. Charges for the use of precious (high noble) or semi-precious (noble) metal are not included in the copayment.	100% Some limitations apply.
Implant	Not covered	80% up to a maximum of $1,250 per patient per calendar year	Not covered. Member receives a 35% discount at provider offices.	Not covered	Not covered	Covered at a nominal copay
PLAN C - ORTHODONTIC SERVICES UNDER THE DENTAL PLAN						
	Not covered under the Scheduled Direct Pay Dental Plan (except space maintainers and orthodontic x-rays). Depending on your employer, an orthodontics plan through the Trust Fund, offering a $2,500 benefit may be available.	Not covered under the Delta Dental Plan (except space maintainers). Depending on your employer, an orthodontics plan through the Trust Fund, offering a $2,500 benefit may be available.	Available through Newport with a $2,500 copayment (plus work-up fees) Some limitations and exclusions apply. Depending on your employer, an orthodontic plan through the Trust Fund, offering a $2,500 benefit may be available.	Available through MetLife with a $2,500 copayment (plus work-up fees). Some limitations and exclusions apply. Depending on your employer, an orthodontics plan offering a $2,500 benefit may be available.	Available through United Concordia Plus with a $1,500 copayment for adolescents ($2,000 for adults). Some limitations and exclusions apply. Depending on your employer, an orthodontics plan offering a $2,500 benefit may be available.	Available through United HealthCare Dental with a $1,250 copayment (plus work-up fees). Some limitations and exclusions apply. Depending on your employer, an orthodontics plan offering a $2,500 benefit may be available.

* Dental benefits available under certain bargaining agreements may vary from those shown.

NOTES

Automotive Industries Welfare Fund
4160 Dublin Blvd., Suite 400 Dublin, CA 94568
800-635-3105

AUTOMOTIVE INDUSTRIES WELFARE FUND

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Qualifying Event

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

- Your hours of employment are reduced, or
- Your employment ends for any reason, other than gross misconduct.

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

- Your spouse's hours of employment are reduced (causing a loss of coverage);
- Your spouse's employment ends for any reason, other than gross misconduct;
- Your spouse dies; or
- You become divorced or legally separated from your spouse.

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

- The employee's hours of employment are reduced (causing a loss of coverage);
- The employee's employment ends for any reason, other than gross misconduct;
- The employee becomes divorced or legally separated;
- The employee dies; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or death of the employee, the employer must notify the Fund Office of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you must notify the Fund Office within 60 days after the loss of coverage due to the qualifying event. You must provide this notice to:

Automotive Industries Welfare Fund
c/o Health Services & Benefit Administrators (HSBA)
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
Telephone (800) 635-3105
Fax (925) 588-7121

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage for your dependents lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. If the employee became entitled to Medicare benefits less than 18 months before this qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for the employee's spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

(1) Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To get this extension, you must send a copy of the Social Security Award within 60 days of the date of the latest of (1) the date of the Social Security Disability Award, (2) the date that the qualified beneficiary loses coverage, or (3) Prior to the expiration of the original 18-month period of COBRA continuation coverage. Be sure to send the Fund Office a copy of the Social Security Disability Award as soon as you receive it.

(2) Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits after the qualifying event (under Part A, Part B or both), or gets divorced or legally separated, or if a dependent child stops being eligible under the Plan as a dependent child.

Cost to You for COBRA Continuation Coverage

You and/or your covered dependents will have to pay 102% of the full cost of the coverage during the COBRA continuation period. However, any individual or family whose coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits must pay 150% of the full cost of coverage during the 11-month extension of COBRA continuation coverage.

You may choose:

* Medical and prescription drug (if provided to you as of the date of the Qualifying Event); or
* Medical, prescription drug, dental, orthodontia, and vision (if provided to you as of the date of the Qualifying Event).
* Medical, prescription drug, life insurance, dental, orthodontia, vision (if provided to you as of the date of the Qualifying Event). The life insurance level provided is $25,000.

The Fund Office will notify you of the cost of continuation coverage when it notifies you of your right to elect this coverage. You have a maximum of **45 days** from the date you mail your election form to the Fund Office (as determined by postage cancellation) in which to submit your **first payment**. If you wait until the end of the election period, payment for each full month passed since the date active coverage terminated must be included with the first payment. If payment of the amount due is not received within 45 days of your election, COBRA continuation coverage will terminate.

The amount you and/or your covered dependents must pay for your COBRA continuation coverage will be payable monthly. In order that your eligibility is correctly reflected in the Trust Fund records, **you should automatically send your check or money order to the Fund Office before the first of each month**. No payment will be accepted which is more than 30 days after the first day of the coverage month. If payment of the amount due is not received by the end of the 30-day grace period, COBRA continuation coverage will terminate.

Termination before end of maximum period

Continuation coverage will be terminated before the end of the maximum period if:

- The Fund no longer provides coverage to any of its similarly situated individuals,
- Any required premium is not paid in full on time,
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan,
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage.
- Your former employer no longer provides for group health coverage through this Plan; however, the following exceptions apply to this rule:

a) If the employer goes out of business, continuation coverage will continue to be available for its former employees subject to all other limitations on such coverage and,

b) If the union is decertified as the bargaining representative of the Class 1 employees of the employer, class 1 employees on continuation coverage as of the month of the decertification or before will be entitled to continue their continuation coverage subject to all other limitations on such coverage. All other employees of such employer shall have their continuation coverage terminated.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Cal-COBRA

If at the time of a qualifying event your medical and prescription drug coverage is provided through a health maintenance organization, your coverage which would otherwise end under federal law may be required to be extended by HMO to a total of 36 months under California law. For participants enrolled in Kaiser Permanente, Cal-COBRA would include your prescription drug benefit. You must contact Kaiser Permanente directly immediately upon the expiration of your federal COBRA coverage to receive these additional Cal-COBRA benefits.

Domestic Partner

Domestic partners and children of a domestic partner are offered "COBRA-like" temporary continuation; however, they do not have all the federally protected rights offered to a Qualified Beneficiary. There may be tax implications for covering a domestic partner or children of a domestic partner. You should consult with a tax specialist on this matter.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Conversion

If you have Kaiser HMO coverage, you may have the right, when your group health coverage ends, to enroll in an individual conversion Kaiser HMO policy, without providing proof of insurability. The benefits provided under such an individual conversion policy will not be identical to those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You must contact Kaiser Permanente directly to receive individual conversion coverage. Time limits apply so you must contact Kaiser Permanente immediately upon the expiration of your health plan coverage, federal COBRA coverage or additional Cal-COBRA coverage.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Fund Office know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office. Plan contact information is as follows:

Automotive Industries Welfare Fund
c/o Health Services & Benefit Administrators (HSBA)
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
Telephone (800) 635-3105
Fax (925) 588-7121

Contact the "COBRA Unit" at the group health plan at the address and phone numbers shown above.

IMPORTANT EMPLOYEE BENEFIT PROGRAM NOTICES

HIPAA Special Enrollment Rights

After this open enrollment period is completed, generally you will not be allowed to change your benefit elections or add/delete dependents until next years' open enrollment, unless you have a Special Enrollment Event as outlined below:

- **Special Enrollment Event:**

  If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

  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. However, you must request enrollment within 31 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.
  - 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.

  To request special enrollment or obtain more information, contact the Trust Fund Office.

You must notify the Fund in writing within 31 days of the mid-year change in status event by contacting the Fund Office. The Fund Office will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the month, following the approved change in status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

Failure to give the Fund a timely notice (as noted above) may:

- Cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
- Cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
- Cause claims to not be able to be considered for payment until eligibility issues have been resolved,
- Result in your liability to repay the Fund if any benefits are paid to an ineligible person.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact the Trust Fund Office at (800) 635-3105.

Privacy Notice

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the plan. You can get another copy of this Notice from the Fund Office.

Important Reminder To Provide The Plan With The Taxpayer Identification Number (TIN) Or Social Security Number (SSN) Of Each Enrollee In A Health Plan

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the Trust Fund Office at (800) 635-3105.

Availability Of Summary Health Information: The Summary Of Benefit And Coverage (SBC) Document(s)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the Summary of Benefits and Coverage (SBC), summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages long the SBC should be, the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, contact the Trust Fund Office at (800) 635-3105.

Caution: If You Decline Medical Plan Coverage Offered Through Auto Industries

The medical plan options offered by Automotive Industries are considered to be minimum essential coverage (MEC) and meets the government's minimum value standard. Additionally, the cost of medical plan coverage is intended to be affordable to employees, based on employee wages.

If you are in a benefits-eligible position and choose not to be covered by one of Automotive Industries medical plan options, you must maintain medical plan coverage elsewhere or you can purchase health insurance through a Marketplace (www.healthcare.gov), typically at the Marketplace annual enrollment in the fall each year.

Americans without medical plan coverage could have to pay a penalty when they file their personal income taxes. Visit the Health Insurance Marketplace for detailed information on the individual shared responsibility payment penalty at https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/.

If you choose to not be covered by a medical plan sponsored by Automotive Industries at this enrollment time, your next opportunity to enroll for your employer's medical plan coverage is at the next annual open enrollment time, unless you have a mid-year change event that allows you to add coverage in the middle of the plan year.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP):

Direct Pay Plan:

The Direct Pay Plan offered by this Fund does not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider.

Kaiser HMO:

The Kaiser HMO medical plans generally require the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make

this designation, Kaiser designates one for you. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser.

Direct Access to OB/GYN Providers (Direct Pay Plan and Kaiser HMO Plans):

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Trust Fund Office.

Medicare Notice of Creditable Coverage

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Plan options available to you are or are not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the plan options offered by the Fund is or is not creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage available from Fund Office.

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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