AUTOMOTIVE INDUSTRIES WELFARE FUND

PLAN B

HEALTH PLAN ENROLLMENT GUIDE

EFFECTIVE JANUARY 1, 2021

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Automotive Industries Welfare Fund
Administered By: Health Services & Benefit Administrators (HS&BA)
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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
Delta Dental of CA	866-499-3001	www.deltadentalofCA.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 and Kaiser HMO material which govern plan benefits. If any conflict arises between this Guide and the SPD or Kaiser HMO materials, the SPD or Kaiser 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 B Medical** if your employer has negotiated Plan B 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 Permanente (HMO) -** With an HMO, you must receive all your care through a Kaiser hospital or Kaiser physician contracted with the HMO in which you are enrolled. Non-Kaiser expenses will only be covered for emergency services. You must live or work within the service area to enroll. Covered charges are not subject to a lifetime maximum.

  If you enroll in Kaiser, you must select a Primary Care Physician (PCP). You must use only Kaiser physicians and facilities. An annual deductible of $500 ($1,000 for a family) applies to all benefits except doctor office visits and preventive care. Once the deductible is satisfied, you must pay a small copayment.

- In the **Direct Pay Plan**, unlike an HMO, medically necessary care from any provider practicing within the scope of his or her license that you select will be covered in accordance with 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 Advantage Preferred Provider Organization 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 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 for an individual/$3,000 for a family ($500 for an individual/$1,500 for a family if you participate in the wellness program) in medical expenses every year (a larger deductible applies for Washington residents). You must then pay a portion of covered expenses. In general, the plan will pay 85% of contracted rates for an Advantage PPO provider and 50% of allowed charges for a provider not contracted with Anthem Blue Cross or the National Blue Cross/Blue Shield Association. The maximum annual out-of-pocket expenses paid directly to an Advantage PPO provider for an individual is $1,500 ($3,000 for 2 family members and $4,400 per family).

As a Direct Pay participant, you will also be eligible for a **Health Reimbursement Account** (HRA). Current contribution for plan is a $50 per month for a total of $600 annually. Your HRA dollars can then be used by you and your dependents for deductibles and other eligible medical, prescription drug, dental and vision expenses that are not reimbursed from any other health plan. You must be covered under the Direct Pay Plan in order to qualify for the HRA account. Unspent funds on your HRA account will continue to accumulate and will remain available as long as you remain covered on the Direct Pay Plan. 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.

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

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 mental health, substance abuse issues, wellness and nutrition advice. Effective for services received on or after March 18, 2020 through the end of the emergency period in which the federal government has announced a Public Health National Emergency, Anthem Blue Cross LiveHealth Online services will have no cost-sharing (no deductible, coinsurance, or copay). For all other LiveHealth Online services received before or after the Emergency Period, your copayment is a $20 (deductible waived). To access this program, you can sign up at www.livehealthonline.com.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Starting September 1, 2014, 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 for you and your dependents.

- Your employer will provide funding for your HRA. The amount of the funding is based on the Agreement between your employer and the Union. In order to receive twice the amount on the HRA for family, the dependent(s) must be added at the same time during initial enrollment; otherwise, the full load will take place the 1st of January.
- 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.
- For new eligible participants, you will receive a prorated amount based on your employer's participation date for the HRA program.
- An additional $50 per month HRA credit will be provided to those who enroll in the Direct Pay Plan instead of Kaiser. This is in addition to any HRA amount provided by your employer. The balances on your card will carry forward in addition to the new HRA amount.
- 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 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, vison 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.

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 $1,500 ($3,000 for 2 family members and $4,500 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 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 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.

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 (up to age 21).

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.

COVID-19 SERVICES

Effective for services received on or after March 18, 2020 and through the end of the Emergency Period in which the federal government has announced a Public Health National Emergency, the Fund covers COVID-19 testing and related visits/services from either an in-network or out-of network provider at 100% of the allowed charge, with no cost sharing (no deductible, copay or coinsurance). No prior authorization is required. Some medical services associated with the treatment of COVID-19 by an in-network provider may be covered at 100% of the allowed charge. Please reach out to the Fund Office for more information.

ELIGIBILITY AND ENROLLMENT - WHO IS ELIGIBLE

- **Contract Employees and Owners who work with the tools of the trade (Class 1):** Active Employees working under a bargaining agreement between an employer and a participating Union, which provides for contributions to the Automotive Industries Welfare Fund in accordance with the provisions of the Trust Agreement. Owners who are working with the tools of the trade and who have a bargaining agreement with a participating union will also be eligible to participate. Employees of a participating Union and the Administrative Office are also included.
- **Non-Contract Employees (Class 2):** A Full-Time Employees, proprietor, or partner of an employer who is actively scheduled to work at least 30 hours each week (or 130 hours each month) at the employer's principle place of business, which is other than the employers residence. An employer that has elected to cover Class 2 Employees must cover all its Class 2 Employees.
- **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 (23 if a student) 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 (23 if a student) 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 (23 if a student) 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. If you have a newborn child and you need to request enrollment within 31-days of the date of birth. The Fund will provide you the enrollment form within 31 days, you will then have an additional 60 days (counted form the end of the 31-day period) to provide your child's Birth Certificate. If the birth certificate is not provided within the 91-day period, coverage for the newborn will terminate and any future coverage will be effective on the first date of the month following the month that the Fund Office receives the enrollment form and birth certificate.
- **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.
- **New Employees** must enroll in the Direct Pay Medical Plan B option for the first 12 months after they become eligible (exception: if a new member was previously covered by Kaiser within the last 12 months and had been covered for at least 12 months through Kaiser and Kaiser was the most recent coverage, then the Kaiser Plan would also be an Option). After the initial 12 months, Employees who live in California have the option to dis-enroll from Direct Pay Medical Plan B and enroll in the Kaiser HMO. The Kaiser HMO plan is not available outside of California. Exception: Kaiser members who have had coverage within 90 days (after ceasing to be eligible for Health and Welfare coverage through Automotive Industries) are eligible to select Kaiser even though they are considered "new hires." In order to be eligible for Kaiser coverage under this rule, you must provide the Fund Office with proof of prior coverage from Kaiser.
- All new hires must enroll in one of the Dental DMOs for the first 12 months after they become eligible unless the employer has purchased the Delta Dental "Buy- Up Plan". Upon completion of the 12-month initial coverage period, the participant may select Delta Dental in addition to the Dental DMO Options.
- A new Employee may elect to enroll in the Delta Dental PPO Plan rather than one of the pre-paid dental options if prior to enrolling in the Plan:
  1. The last dental coverage they had was Delta Dental; and
  2. They were covered by Delta Dental in the preceding 12 months;
  3. They were covered under that Delta Dental Plan for at least 12 months.

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 hired Employees are required to enroll in the Direct Pay Plan for the first 12 months. An exception is if a new employee was covered by Kaiser within the last 12 months, was covered for at least 12 months, and Kaiser was their most recent coverage, then he or she may also select Kaiser. In addition, newly hired Class 2 Employees can enroll in 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 of 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 page 26 HIPAA Special Enrollment Rights section in this Guide). This would include certain events such as 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. Note that coverage for a newborn or newly adopted child must be retroactive to the date of birth or placement for adoption if the request is made within 31 days.
- 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 you would like to change plans and enroll in Kaiser HMO, consider whether you have a Kaiser HMO doctor 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 versus more predictable health care costs**
  - The Direct Pay Plan offers more freedom, letting you use any doctor or hospital. If you use Blue Cross Advantage network hospitals, laboratories, physicians or specialists, you will benefits at lower out-of-pocket costs.
  - Note that most Sutter-affiliated physicians, hospitals and outpatient providers are not a part of the Advantage network (even though they may be part of the larger Anthem PPO network).
  - If you are most concerned with budget, you may find that Kaiser HMO is better suited to your needs.
- **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 HMO only provide emergency care outside their service area.
- **Convenience of facilities**: Look at where the Kaiser HMO 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 through COBRA. Refer to pages 19-25 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, contracts with the Kaiser HMO and the Rules and Regulations present benefits in more detail. If any conflict arises between this Guide and the SPD, the contracts with the Kaiser HMO 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 B - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	**DIRECT PAY (Anthem Blue Cross Advantage PPO)**	**KAISER PERMANENTE**
Group Number **Member Services Telephone Numbers**	Anthem Blue Cross Advantage PPO (APPO) Network & Review Organization (800) 274-7767 Claims: (800) 635-3105	Group 57-1 (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.	Deductible Health Maintenance Organization (DHMO) 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 an Advantage PPO Hospital, Laboratory, Physician, or Specialist.	Use Kaiser Permanente hospitals and physicians. You may select a personal Kaiser Permanente physician.
Specialized Care *In-Network*	85% of APPO contracted rates	100% after $20/visit when your Primary Care Physician refers you to a Kaiser Permanente specialist
Outside Network	50% of allowed (Usual, Customary & Reasonable) charges	100% after $20/visit if Kaiser Permanente physician refers you to outside specialist
Percentage Payable	**APPO Provider:** 85% of contracted rates **Non-PPO Provider**: 50% of allowed charges	80% after applicable copayment amount
Out-of-Area Care * "Emergency" is defined in the Plan Booklet.	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. 20% member copayment (waived if admitted)
Claims	File claims with the Automotive Industries Welfare Fund	No claim forms except for out-of-plan emergency care from non-Kaiser Permanente providers.

PLAN B - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES

BENEFITS	DIRECT PAY (Anthem Blue Cross Advantage PPO)	KAISER PERMANENTE
Medical Plan Calendar Year Deductible (medical, mental health and substance abuse) * A larger deductible ($2,000 per person and $6,000 per family or $1,000 per person and $3,000 per family if you participate in the wellness program) applies for Washington residents.	Deductible accumulates towards Out-of-Pocket Limit. Deductible does not apply to PPO preventive care. In addition, a LiveHealth online visit, COVID-19 test/test related visit/services, and PPO COVID-19 treatment from March 18, 2020 through the end of the Public Health Emergency Period is not subject to a Deductible. Per Person: $1,000 * ($500 if you participate in the wellness program) Per Family: $3,000 * ($1,500 if you participate in the wellness program)	Applies to all benefits except doctor office visits and preventive care Per Person: $500 Per Family: $1,000
Health Reimbursement Account (HRA) • The HRA amounts depend on what has been negotiated between your employer and the union. • Contribution made every January 1	Option 1 / Option 2 Single $500 / $1.000 Two Party $1,000 / $2,000 Family $1,500 / $3,000 In addition, a $50 per month credit is made to the HRA account.	Option 1 / Option 2 Single $500 / $1.000 Two Party $1,000 / $2,000 Family $1,500 / $3,000
Out-of-Pocket Calendar Year Maximum (maximum will accumulate all medical, and mental health and substance abuse) **There is a separate out-of-pocket maximum for in-network prescription drugs which is outlined on page 13**	The Out-of-Pocket Limit for cost-sharing for in-network APPO copayments, coinsurance and deductibles (and non-PPO emergency room for an emergency) are as follows: Single $1,500 Two Party $3,000 Family $4,400 No Out-of-Pocket limit for cost-sharing for Non-PPO providers. In-Area, non-PPO network provider charges do not apply to the maximum.	The Out-of-Pocket Limit for cost-sharing for in-network copayments, coinsurance and deductible as follows: Single $3,000 Family $6,000

PLAN B - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	**DIRECT PAY (Anthem Blue Cross Advantage PPO)**	**KAISER PERMANENTE**
Hospital *Inpatient*	**APPO Hospital**: 85% of contracted rates **Non-PPO Hospital**: 50% of allowed charges (Benefits are reduced by $250 if pre-authorizations is not obtained from Anthem Blue Cross.)	80% after deductible
Outpatient Surgery	**APPO Hospital**: 85% of contracted rates **Non-PPO Hospital**: 50% of allowed charges	80% per procedure after deductible
Emergency Services *"Emergency" is defined in the Plan Booklet"*	**APPO 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% per admit after deductible (waived if admitted)
Maximum Allowable Charge (MAC)	You will be responsible for charges in excess of the MAC. To avoid any balance billing, use a Value Based Site or an in-network licensed Ambulatory Surgery Center.	
Hip and Knee	$35,000 per surgery at an inpatient hospital in the State of California	Not applicable
Arthroscopy	$6,000 per surgery at an outpatient hospital (instead of an ambulatory surgical center)	Not applicable
Cataract Surgery	$2,000 per surgery at an outpatient hospital (instead of an ambulatory surgical center)	Not applicable
Colonoscopy	$1,500 per surgery at an outpatient hospital (instead of an ambulatory surgical center)	Not applicable
Home Health Care	Limited to 150 visits per calendar year **APPO Provider**: 85% of contracted rates **Non-PPO Provider**: 50% of allowed charges	100% up to 100 visits per calendar year (when authorized by Plan Physician and Committee)
Hospice Care	**APPO Provider**: 85% of contracted rates **Non-PPO Provider**: 50% of allowed charges	100% when authorized by Plan Physician

PLAN B - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	**DIRECT PAY (Anthem Blue Cross Advantage PPO)**	**KAISER PERMANENTE**
Diagnostic X-Ray and Lab	**APPO Provider:** 85% of contracted rates **Non-PPO Provider:** 50% of allowed charges	$10 copayment after deductible except specialized radiological procedures (CT, MRI, PET) are covered at 20% up to a maximum of $50/procedure after deductible. Preventive x-rays, screenings, and laboratory tests are no charge (deductible does not apply)
Allergy *Testing*	**APPO Provider**: 85% of contracted rate **Non-PPO Provider**: 50% of allowed charges	100% after $20/visit
Injection	**APPO Provider**: 85% of contracted rate **Non-PPO Provider**: 50% of allowed charges	100% for injections after deductible
Physical Therapy (*Outpatient)*	Limited to 12 visits per calendar year (if the therapy is provided for recovery from a stroke or in connection with a related surgical procedure performed within 24 months of the therapy either on a pre-operative or post-operative basis, the Plan will cover up to but no more than 24 total visits in one calendar year) **APPO Provider**: 85% of contracted rates **Non-PPO Provider**: 50% of allowed charges	100% after $20/visit after deductible when authorized by Plan physician
Physician Fees *Surgery*	**APPO Provider**: 85% of contracted rates **Non-PPO Provider**: 50% of allowed charges	80% per procedure after deductible has been met
Office Visits/Consultation	**APPO Provider**: 85% of contracted rates **Non-PPO Provider**: 50% of allowed charges	100% after $20/visit
Hospital Admission Visit *Hospital Follow-Up Visit*	**APPO Provider**: 85% of contracted rates **Non-PPO Provider**: 50% of allowed charges	80% after deductible 80% after deductible
Skilled Nursing Facility Care	Limited to 120 days per disability **APPO Provider**: 85% of contracted rates **Non-PPO Provider**: 50% of allowed charges	80% per admission (after deductible) for up to 100 days per benefit period of prescribed care

PLAN B - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
Preventive Care for Men	**APPO** preventive care that is required to be covered under Health Care Reform (including any COVID-19 preventive services (e.g., vaccines) within 15 business days after the date on which relevant body (U.S. Preventive Services Task Force or CDC) makes recommendation) 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. In addition, any COVID-19 preventive services (e.g., vaccines) within 15 business days after the date on which relevant body (U.S. Preventive Services Task Force or CDC) makes recommendation through the end of the Public Health emergency period.	100%
Preventive Care for Women (including Contraception)	**APPO** preventive care that is required to be covered under Health Care Reform (including any COVID-19 preventive services (e.g., vaccines) within 15 business days after the date on which relevant body (U.S. Preventive Services Task Force or CDC) makes recommendation) 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. In addition, any COVID-19 preventive services (e.g., vaccines) within 15 business days after the date on which relevant body (U.S. Preventive Services Task Force or CDC) makes recommendation through the end of the Public Health emergency period.	100%
Preventive Care for Dependent Child	**APPO** preventive care that is required to be covered under Health Care Reform (including any COVID-19 preventive services (e.g., vaccines) within 15 business days after the date on which relevant body (U.S. Preventive Services Task Force or CDC) makes recommendation) will be payable at 100%, no deductible. **Non-PPO Provider**: Preventive care with a non-PPO provider will not be covered. **Exception**: any COVID-19 preventive services (e.g., vaccines) within 15 business days after the date on which relevant body (U.S. Preventive Services Task Force or CDC) makes recommendation through the end of the Public Health emergency period.	100%

PLAN B - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
Maternity Care *Pre-Natal Care*	**APPO provider**: 85% of contracted rates. Prenatal preventive screenings are required to be covered under Health Care Reform will be payable at 100%, no deductible. **Non-PPO Provider**: 50% of allowed charges. Prenatal preventive screenings with a non-PPO provider will not be covered.	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)	**APPO provider**: 85% of contracted rate **Non-PPO provider**: 50% of allowed charges	80% after deductible has been met
Other Services *Ambulance*	**APPO provider**: 85% of contracted rates **Non-PPO provider**: 85% of allowed charges	$150 per trip after deductible has been met when medically necessary and authorized by Plan physician. Air ambulance must be arranged for in advance by health plan.
Infertility Services	Not covered	50% of charges including drug (In vitro fertilization not covered). Deductible does not apply.
Voluntary Sterilization	**APPO provider**: No charge for female sterilization. 85% of contracted rates for vasectomies after deductible. **Non-PPO provider**: 50% of allowed charges (Limited to Employee and Spouse)	No charge for female sterilization procedures. Deductible does not apply. 80% for male sterilization procedures if provided in an outpatient or ambulatory surgery center or in a hospital room.
Durable Medical Equipment	**APPO provider**: 85% of contracted rates **Non-PPO provider**: 50% of allowed charges	80% when prescribed by Health Plan physician. Some limitations and exclusions apply.
Prosthetic/Orthopedic Appliances	**APPO provider**: 85% of contracted rates **Non-PPO provider**: 50% 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. **APPO provider**: 85% of contracted rates **Non-PPO provider**: 50% of allowed charges	Not Covered
Vision Care	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

PLAN B - MEDICAL PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	**DIRECT PAY (Anthem Blue Cross Advantage PPO)**	**KAISER PERMANENTE**
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% after $20 copayment for exams only. Deductible does not apply.
Alcohol and Substance Abuse *Inpatient*	This coverage is provided by Anthem Blue Cross. **APPO provider**: 85% of contracted rates **Non-PPO provider**: 50% of allowed charges	This coverage is provided by Kaiser. 80% per admit after deductible
Outpatient	**APPO provider**: 85% of contracted rates **Non-PPO provider**: 50% of allowed charges	$20 individual visit / $5 group visit
Mental Health *Inpatient*	This coverage is provided by Anthem Blue Cross. **APPO provider**: 85% of contracted rates **Non-PPO provider**: 50% of allowed charges	This coverage is provided by Kaiser. 80% after deductible; unlimited number of days
Outpatient	**APPO provider**: 85% of contracted rates **Non-PPO provider**: 50% of allowed charges	100% after $20 per individual visit or $10 per group visit; unlimited number of days
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.	Treatment through Kaiser is self-referred and does not require preauthorization.
Employee Assistance Program (EAP) • Employee only Dependents are not eligible for EAP benefits.	This coverage is provided by HMC 1-3 sessions. $0 copay, 24-hour, toll-free access (legal, financial, elder care, childcare services & identity theft prevention assistance) Toll-free number: (888) 690-1349 https://www.hmchealthworks.com	This coverage is provided by HMC 1-3 sessions. $0 copay, 24-hour, toll-free access (legal, financial, elder care, childcare services identity theft prevention assistance) Toll-free number: (888) 690-1349 https://www.hmchealthworks.com

PLAN B – PRESCRIPTION DRUG PLAN COMPARISON FOR ACTIVE EMPLOYEES		
BENEFITS	**DIRECT PAY (Anthem Blue Cross Advantage 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 Contraceptives:** No copay or deductible for generic contraceptives (or brand if generic is medical inappropriate). **ACA Preventive Care Drugs -** No copay or deductible for preventive care drugs required under Health Care Reform. This includes, but is not limited to, FDA approved generic tobacco cessation products (both prescription and over the counter medications) for a 90-day treatment regimen (two cycles).	This coverage is provided through Kaiser
Out-of-Pocket Calendar Year Maximum	Single $1,500 Two Party $3,000 Family $4,500	Prescription drug out-of-pocket coinsurance and copayments accrue toward to medical out-of-pocket.
Deductible	None	None
Retail Pharmacy * Maximum co-payment of $100 per brand name prescription if the brand name drug is unavailable as generic and unavailable through mail order.	Formulary Generic: 20% plus $5 copay Formulary Brand: 20% * Non-Formulary: 20% plus $15 copay * Injectables: 20% * Day Supply: 30 days	Generic: $15 copay Brand Name: $30 copay 30-day supply
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 Specialty Drug: 20% with a $100 maximum co-payment and 30-day supply	Mail delivery from a Kaiser Permanente pharmacy available for refill prescriptions only. Generic: $30 copay Brand Name: $60 copay 100-day supply

PLAN B - DENTAL PLAN COMPARISON FOR ACTIVE EMPLOYEES				
GENERAL INFORMATION	**DELTA DENTAL PREFERRED PLAN ***	**METLIFE COMPANY**	**UNITED CONCORDIA PLUS**	**UNITED HEALTHCARE DENTAL**
Group Number **Member Services Telephone**	Group No. 2824 (800) 765-6003	Group No. 142616 (800) 880-1800	Group No. 740306 (866) 357-3304	Group No. 711992 PVRC 0001 (800) 999-3367
Type of Plan/ Choice of Providers	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 "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 UnitedHealthcare Dental network
Out-of-Area	Provide all covered benefits at the lower coinsurance	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	No	No	No	No

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

PLAN B - DENTAL PLAN COMPARISON FOR ACTIVE EMPLOYEES				
GENERAL INFORMATION	**DELTA DENTAL PREFERRED PLAN ***	**METLIFE COMPANY**	**UNITED CONCORDIA PLUS**	**UNITED HEALTHCARE DENTAL**
Yearly Maximum	$3,000 (does not apply to pediatric dental services up to age 21)	None	None	None
Benefits Payable	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.
Diagnostic and Preventative Services	Delta Preferred Dentist - 80% of covered expenses** Non-Delta Preferred Dentist - 70% of covered expenses **			
Routine Oral Examination	Limited to two every 12 consecutive months	100%; no frequency limitations	100%	100%
Full Mouth X-Rays	Once every 36 months for full mouth and panoramic x-rays	100%; no frequency limitations	100%; once every three years	100%; once every 24 months
Prophylaxis: all participants	Limited to two per calendar year	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 B - DENTAL PLAN COMPARISON FOR ACTIVE EMPLOYEES				
GENERAL INFORMATION	**DELTA DENTAL PREFERRED PLAN ***	**METLIFE COMPANY**	**UNITED CONCORDIA PLUS**	**UNITED HEALTHCARE DENTAL**
Basic Services Fillings (Amalgams or Composites)	Delta Preferred Dentist - 80% of covered expenses Non-Delta Preferred Dentist - 70% of covered expenses	100%	100%, except resin fillings on posterior teeth have an $85 - $140 copayment.	100%
Major Restorations Crowns, inlays, onlays and cast restorations	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. Charges for the use of precious (high noble) or semi-precious (noble) metal are not included in the copayment.	100% Some limitations apply. Upgrade available at $150 copay per crown.
Endodontics Root Canal	Delta Preferred Dentist - 80% of covered expenses Non-Delta Preferred Dentist - 70% of covered expenses Some limitations apply.	100% Some limitations apply.	100%	100%
Periodontics Services treating teeth affected by diseased gingiva (gums)	Delta Preferred Dentist - 80% of covered expenses Non-Delta Preferred Dentist - 70% of covered expenses	100%	100% except $92-$120 copay for bone replacement grafts, $43 copay for localized delivery of antimicrobial agents, per tooth, and $25 copay for gingival irrigation, per quadrant.	100%
Prosthodontics *Bridges, partial dentures and full dentures*	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. Charges for the use of precious (high noble) or semi-precious (noble) metal are not included in the copayment.	100% Some limitations apply.
Implants	80% up to a maximum of $1,250 per patient per calendar year ^	Not covered	Not covered	Covered at a nominal copay

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

^ Implant max applies to ALL implant related procedures, including, but not limited to, surgical placement of implants, implant cleaning and repair, implant removal, implant abutments, sinus augmentation and implant-supported crowns, dentures and retainers.

PLAN B - ORTHODONTIC SERVICES UNDER THE DENTAL PLAN				
GENERAL INFORMATION	**DELTA DENTAL PREFERRED PLAN ***	**METLIFE COMPANY**	**UNITED CONCORDIA PLUS**	**UNITED HEALTHCARE DENTAL**
	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 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 UnitedHealthcare Dental with a $1,250 copayment for adult/child (for 24 months treatment). 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

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), eligible employees and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace (the Marketplace helps people without health coverage find and enroll in a health plan, (for California residents see: www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov)).

In the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit.

You may also qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this enrollment information is intended to expand a person's COBRA rights.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an Employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

- A child of the covered Employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
- A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

Qualifying Event

Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e.g.* employee continues working even though entitled to Medicare) then COBRA is not available.

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 causing a loss in coverage (including strikes or lockouts), or
- Your employment ends for any reason, other than gross misconduct.

If you are the Spouse or Dependent Child of a covered employee, you will become a qualified beneficiary if you 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 (including strikes or lockouts);
- 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 initial Qualifying Event is termination of employment or reduction of hours causing a loss of coverage, 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) or any notice of a second Qualifying Event, 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 (HS&BA)
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. 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. The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries		
	Employee	**Spouse**	**Dependent Child(ren)**
Employment terminates (for other than gross misconduct), including retirement.	18 months	18 months	18 months
Employee reduction in hours worked including strikes and lockouts (making employee ineligible for coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 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, prior to the Qualifying Event or during the first 60 days of an 18-month COBRA period, 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, prescription drug, and burial (if provided to you as of the date of the Qualifying Event); or
- Medical, prescription drug, burial, dental, orthodontia, and vision (if provided to you as of the date of the Qualifying Event).
- Medical, prescription drug, burial, life insurance, dental, orthodontia, vision (if provided to you as of the date of 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**. 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.

Thereafter, 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.

For Monthly Payments, What If The Full COBRA Premium Payment Is Not Made When Due?

If the Fund Office receives a COBRA premium payment that is not for the full amount due, the Fund Office will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the Fund Office will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall.

- If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

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.
- During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;
- 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).

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Fund Office determines that COBRA coverage will terminate early.

Once COBRA coverage terminates early, it cannot be reinstated.

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.

Conversion Coverage

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. 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

This Plan complies with Special Enrollment Rights under the Health Insurance Portability and Accountability Act of 1996 because all eligible Employees and their eligible Dependents are covered for benefits when they meet the eligibility requirements. No Employee contribution is required for coverage.

You are allowed to "opt-out" of (or choose not to have) medical coverage. Following is a description of the times that you will be able to re-enroll in the plan.

- If you are not enrolled for coverage under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for yourself and/or your new Spouse, Domestic Partner and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. The Trust will provide 60 days coverage for a newborn. To extend coverage beyond the 60-day period, the Employee must submit the required documents within 60 days of the event.
- **Loss Of Other Coverage:** If, you did not request enrollment under this Plan for yourself, your Spouse/Domestic Partner and/or any Dependent Child(ren) within **31 days** after the date on which coverage under the Plan was previously offered because you or they had coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance, Medicare or other public program) **and** you, your Spouse and/or any Dependent Child(ren) **lose coverage** under that other plan or health insurance policy; you may request enrollment for yourself and/or your Dependents within **31 days** after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:
  - loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
  - termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
  - the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was "exhausted;" or
  - moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
  - the other plan ceasing to offer coverage to a group of similarly situated individuals; or
  - the loss of dependent status under the other plan's terms; or
  - the termination of a benefit package option under the other plan, unless substitute coverage offered.

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

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 Automotive 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.

As required by the Affordable Care Act, each year you will receive an IRS form (called Form 1095-B) in the mail if you or your dependents have been covered under a medical plan during the year. For each month of the calendar year that you were enrolled in a medical plan, this 1095-B form documents that you (and any enrolled family members) met the federal requirement to have "minimum essential coverage," meaning group medical plan coverage.

If you receive a 1095 form, you will want to keep this form in a safe place because you may need to produce it if requested by the IRS. (For large employers, a copy of the form 1095 will also be provided to the IRS.)

Reminder: if you have not been covered by a medical plan during the calendar year you will not receive a Form 1095-B. If you have been covered by various medical plans during the calendar year, you may receive more than one IRS form.

Note that if you are a resident of certain states, such as Massachusetts, New Jersey, California, or Vermont, you may be subject to a state income tax penalty if you fail to maintain medical plan coverage that meets that state's minimum coverage requirements. Consult with your own state's insurance department for information on whether your state has adopted or will be adopting a state Individual Mandate penalty.

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 Plans 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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

ALASKA – Medicaid	FLORIDA – 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: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

NOTICE REGARDING WELLNESS PROGRAM

The Health Dynamics Program is a voluntary wellness program available to all participants and eligible spouses in the Automotive Industries Welfare Fund. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary questionnaire that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test that is likely more extensive than you would routinely obtain in order to determine certain health risks. You are not required to complete the questionnaire or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a lower annual deductible as well as a gift card. Although you are not required to complete the questionnaire or participate in the biometric screening, only employees and their spouses/domestic partners who do so will receive lower deductible.

The information from your questionnaire and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Automotive Industries Welfare Fund may use aggregate information it collects to design a program based on identified health risks in the workplace, the Health Dynamics Program will never disclose any of your personal information either publicly, to the Fund or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to the Fund, your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the Health Dynamics health educator in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your Fund records and personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any Fund benefit decision or employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Fund Office at (800) 635-3105.

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