AUTOMOTIVE INDUSTRIES TRUST FUNDS

4160 DUBLIN BOULEVARD SUITE 400 | DUBLIN, CA 94568-7756
TELEPHONE (800) 635-3105 | FAX (925) 588-7121
www.aitrustfunds.org

Date: **December 10, 2020**

To: **Participants in the Automotive Industries Welfare Fund Plan (including COBRA Participants) who are enrolled in the Indemnity Plan (Plan A or Plan B)**

From: **Board of Trustees, Automotive Industries Welfare Fund Plan**

This Participant Notice provides **information that is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

WELLNESS PROGRAM EXAM REQUIREMENT SUSPENDED FOR PLAN YEAR 2021

The Board of Trustees have made the decision to suspend the wellness program testing requirement for the Calendar Year 2021 (January 1 – December 31). Services received on or after January 1, 2021, will apply to the deductible level that you were at effective December 31, 2020.

ACTION TO BE TAKEN BY PARTICIPANTS ALREADY IN THE LOWER DEDUCTIBLE COVERAGE

If you or your family were on the lower deductible plan effective December 31, 2020, **there is no action to be taken**. You will remain on the lower deductible plan for the Calendar Year 2021.

ACTION TO BE TAKEN BY PARTICIPANTS THAT ARE IN THE HIGHER DEDUCTIBLE COVERAGE LEVEL

If you or your family were on the higher deductible plan effective December 31, 2020, or became a new participant anytime in the calendar year 2020, you will have the opportunity to move your coverage to the lower deductible plan in the Calendar Year 2021.

Requirements for Lowering Deductible for Calendar Year 2021:

1) The Participant in the medical plan must have a routine physical exam performed. There is no requirement for the dependent spouse to receive an exam.
2) The Participant must provide a fully executed Exam Certification Form signed by Participant and Physician to the Trust Fund Office. (Due to the National Emergency due to the COVID-19 Pandemic the Trust Fund Office will accept electronic signatures in lieu of physically signed forms.)

Enclosed with this notice is the Exam Certification Form. Forms received in the Trust Fund Office on or before February 28, 2021, will have their deductibles reduced for claims incurred on or after January 1, 2021. Exam Certification Forms received on or after March 1, 2021, will have the deductible lowered for claims incurred starting the month the form was received by the Trust Fund Office.

If you have questions about what deductible level you are in, please contact the Trust Fund Office at (800) 635-3105.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions, you may call the AI Trust Fund Office at (800) 635-3105.

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding this Plan change, please contact the Trust Fund Office.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan.

AUTOMOTIVE INDUSTRIES WELFARE FUND

4160 DUBLIN BLVD., SUITE 400 | DUBLIN, CA 94568
TOLL-FREE: (800) 635-3105 | FAX: (925) 588-7121
WEBSITE: www.aitrustfunds.org E-MAIL: aisupport@hsba.com

2021 WELLNESS PROGRAM – EXAM CERTIFICATION FORM

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

MAILING ADDRESS (STREET OR P.O. BOX)	SEX (M/F)	DATE OF BIRTH

CITY	STATE	ZIP	MAIN NUMBER	MOBILE NUMBER
			( ) -	( ) -

E-MAIL ADDRESS	

MARITAL STATUS	EMPLOYER	DATE OF HIRE
☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER ☐ DIVORCED	OCCUPATION/CLASSIFICATION:	LOCAL #

PERSONAL & DEPENDENT INFORMATION

RELATION	LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH
SELF					
□ SPOUSE □ DOMESTIC PARTNER**					

Certification of Participant

BY SIGNING IN THE AREAS SPECIFIED BELOW, I AM CERTIFYING THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THE PURPOSE OF THIS FORM IS SOLELY FOR THE 2021 WELLNESS PROGRAM EXAM CERTIFICATION AND CANNOT BE USED FOR ANY OTHER ENROLLMENT PURPOSE, INCLUDING, BUT NOT LIMITED TO: CHANGE OF ADDRESS, CHANGE IN DEPENDENTS, CHANGE IN MARITAL STATUS, OR CHANGE IN MEDICAL PLAN OR SERVICE PROVIDER.

EMPLOYEE SIGNATURE: _____ **DATE**:_____

THE BELOW SECTION IS TO BE SIGNED BY YOUR MEDICAL PROVIDER.

PHYSICIAN CERTIFICATION

THIS WILL CERTIFY THAT THE BELOW NAMED PARTICIPANT IN THE AUTOMOTIVE INDUSTRIES WELFARE PLAN WAS SEEN IN MY OFFICE AND RECEIVED A ROUTINE PHYSICAL EXAMINATION AND LABORTORY SCREENING.

PATIENT'S NAME: _____ **DATE OF EXAM** :_____

PHYSICIAN'S SIGNATURE: _____ **DATE**:_____