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: **April 1, 2024**

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

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.

PHYSICAL EXAM REQUIRED TO LOWER YOUR DEDUCTIBE LEVEL FOR 2025 CALENDAR YEAR

In 2023 the Board of Trustees instituted an annual physical exam requirement for those on the self-funded medical plans offered by the Automotive Industries Welfare Plan in order to receive a lower calendar year deductible. The participant and their spouse or domestic partner (if applicable) who get an annual physical exam will be moved to the lower deductible level along with all dependent children. The physical exam can be taken any time before the end of the 2024 calendar year (December 31) and requires the Plan's certification form to be sent to the Trust Fund Office.

Plan Option	Annual Calendar Year Deductible	2025 Deductible IF you and your Spouse/Registered Domestic Partner receive a physical exam in 2024	2025 Deductible IF you and your Spouse/Registered Domestic Partner do NOT receive a physical exam in 2024
Plan A	**$400**/individual or **$800**/family	**$200**/individual, **$400**/family	**$400**/individual or **$800**/family
Plan B	**$1,000**/individual or **$3,000**/family	**$500**/individual, **$1,500**/family	**$1,000**/individual or **$3,000**/family
Plan C	**$1,000**/individual, **$2,000**/family	**$500**/individual, **$1,000**/family	**$1,000**/individual, **$2,000**/family

Enclosed with this notice is the Physical Exam Certification Form. A separate form must be submitted for you and your spouse or domestic partner (if applicable) to reduce your deductible for the 2025 calendar year. Forms can also be obtained online at www.aitrustfunds.org .

If you have questions about what deductible level you are in, or have questions regarding this letter, please contact the Trust Fund Office at (800) 635-3105 or by email at AISupport@hsba.com.

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.

NOTICE REGARDING WELLNESS PROGRAM

The Fund has 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 have a complete physical exam during Calendar Year 2024. You are not required to have this exam.

However, employees who choose to participate in the wellness program will receive an incentive of a lower annual deductible. Although you are not required to have the physical exam, only employees who do so will receive lower deductible in 2025.

The information from your physical exam will be used to provide you with information to help you understand your current health and potential risks.

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 Fund will never disclose any of your personal information either publicly, 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 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 Fund in order to provide you with your decreased deductible under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your 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 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 or by email at AISupport@hsba.com .

AUTOMOTIVE INDUSTRIES WELFARE FUND

4160 DUBLIN BLVD., SUITE 400 | DUBLIN, CA 94568
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WEBSITE: www.aitrustfunds.org E-MAIL: aisupport@hsba.com

2024 – PHYSICAL EXAM CERTIFICATION FORM

PARTICIPANT INFORMATION

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 #

INDIVIDUAL RECEIVING PHYSICAL EXAM

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

Certification of Participant / Dependent Spouse / Domestic Partner

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 2023 PHYSICAL EXAM CERTIFICATION TO REDUCE MY DEDUCTIBLE UNDER THE WELFARE PLAN. THIS FORM 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.

SIGNATURE: _____ **DATE**:_____

REMINDER: ***YOU AND YOUR SPOUSE (OR DOMESTIC PARTNER) MUST COMPLETE SEPARATE ANNUAL PHYSICAL EXAM FORMS IN ORDER TO RECEIVE THE LOWER DEDUCTIBLE IN 2025.***

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**:_____