AUTOMOBILE MECHANICS' LOCAL 701 UNION AND INDUSTRY WELFARE FUND

500 West Plainfield Road ~ Suite 203 ~ Countryside, IL 60525
Telephone (708) 482-0110 ~ Toll Free (800) 704-6270 ~ Fax (708) 482-9140

IMPORTANT BENEFIT PLAN CHANGES

The Trustees of the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund have made certain changes to the Summary Plan Description ("SPD") and Plan Document that was previously provided to you. These changes are summarized below.

This document, referred to as a "summary of material modifications," is intended to supplement the SPD. You should retain this summary of material modifications with your copy of the SPD. If you have any questions, you may contact the Fund Office at the numbers listed above.

The **Premier** Summary Plan Description and Plan Document is hereby amended as follows:

1. **Effective January 1, 2014, an additional provision is added to the Exclusions and Limitations for the Weekly Disability Benefit, as provided below:**

Exclusions and Limitations

Weekly Disability Benefits are not paid for any loss of time due to a disability:

- For which you are in receipt of wages, salary, pay for lost time, vacation pay, holiday pay or sick pay from your employer;
- For which you are not under the direct and continuing care of a Physician;
- That is due to an accidental Injury, Illness, or disease that arises out of or in the course of any occupation or employment for remuneration, wage, or profit or for which you are or may be entitled to benefits in whole or in part under workers' compensation, occupational diseases, employer's liability, or similar law.
- If you become eligible under another group health plan;
- While you are covered through COBRA continuation coverage; and
- <u>For any period during which you are receiving a pension or disability pension from the Automobile Mechanics' Local No. 701 Union and Industry Pension Plan.</u>

2. Effective January 1, 2014, pre-certification shall be required for all children under the age of 12 (previously the age of 8) before chiropractic/spinal care benefits are paid. Therefore, the following provisions of the Plans are amended to replace "age 8" with "age 12," as provided below:

Covered Medical Expenses

- Supplies and services rendered by a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic Medicine, Naprapath, or a Registered Physical Therapist (under the direction of a Physician) for treatment of the back, neck, spine, and vertebra for conditions due to subluxation, strains, sprains, and nerve root problems (chiropractic/spinal care) as shown in the Schedule of Benefits. Chiropractic/spinal care expenses for children under the age of 12 are covered only in very limited situations. Pre-certification for children under age 12 is required before chiropractic/spinal care benefits are paid.

What is a Claim

There are four categories of health claims according to the Department of Labor Regulations at 2560.503-1; however, with limited exceptions (e.g., pre-authorization requirement for chiropractic services for Dependent children under the age 12), the Fund generally administers one type of health claim, referred to as "Post-service claims." Post-service claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided, are examples of post-service claims.

Types of Health Care Claims

- Pre-Service — A claim where pre-certification is required before you obtain care. The Plan requires pre-certification of services related to chiropractic or spinal care for children under age 12 and for all transplant procedures.

- Concurrent Care — A claim that is reconsidered after it is initially approved (such as recertification of the number of chiropractic or spinal treatments for children under age 12) and the reconsideration results in reduced benefits or a termination of benefits (other than by Plan amendment or termination).

3. Effective January 1, 2014, the Schedule of Benefits is amended to modify the Calendar Year per family Out-of-Pocket Maximums, as provided below:

Calendar Year Out-of-Pocket Maximums*	
• PPO Maximum	$5,000 per person; $12,700 per family
• Additional Non-PPO Maximum	$3,000 per person; $11,300 per family

***** Excludes amounts paid for non-covered expenses.

4. Effective January 1, 2014, the Schedule of Benefits is amended to modify certain Non-PPO Provider Co-insurance amounts from 70% to 65%, as provided below:

Comprehensive Medical Benefit (Active Employees and their Dependents)		
Type of Service	**PPO Provider**	**Non-PPO Provider**
• Outpatient Pre-Admission Tests	Plan pays 100%; no deductible	Plan pays 100%; no deductible
• Hospital Inpatient and Outpatient Surgeries and Hospital Inpatient Services	Plan pays 80%	Plan pays 65%
• Emergency Room	Plan pays 80% after $400 deductible which is waived if admitted	Plan pays 80% (65% if not Emergency) after $400 deductible which is waived if admitted
• Preventive Services	Plan pays 100%; no deductible	Not covered
• Non-Hospital Services (e.g., Office Visits, Lab Tests)	Plan pays 80%	Plan pays 65%
• Chiropractic Care[1]	Plan pays 80% for up to 12 visits per person per calendar year	Plan pays 65% for up to 12 visits per person per calendar year
• Substance Abuse Treatment[2] – Inpatient – Outpatient	 Plan pays 90% Plan pays 80% of first $5,000 in a year; 50% thereafter	 Plan pays 65%[3] Plan pays 50%
• Mental Health Treatment – Inpatient – Outpatient	 Plan pays 90% Plan pays 50%	 Plan pays 50% Plan pays 50%
• Hearing Aid Program	Plan pays 100% up to $600 per person every three years	Plan pays 100% up to $600 per person every three years

[1] Chiropractic care includes all services and supplies provided by a licensed Chiropractor.

[2] Inpatient treatment is covered if it is provided by a Hospital or approved Treatment Facility and treatment is based on completion of a course of treatment and the discharge is certified by a Physician.

[3] Inpatient treatment provided by a Non-PPO provider is subject to the $500 per person Non-PPO deductible for each non-Emergency admission, in addition to the calendar year deductible.

• Ambulatory Surgical Center	Plan pays 80%	Not covered
• Other Covered Medical Expenses	Plan pays 80%	Plan pays 65%

5. Effective January 1, 2014, the following language is changed in the Section titled "Calendar Year Out-of-Pocket Maximum for Active Employees," as follows:

Amounts paid for non-covered expenses do not count toward the Plan's calendar year out-of-pocket maximum. See the notes following the Schedule of Benefits for more details or contact the Fund Office with questions.