AUTOMOBILE MECHANICS' LOCAL 701 UNION AND INDUSTRY WELFARE FUND

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

1. **Effective January 1, 2014, the Schedule of Benefits for the Comprehensive Medical Benefit (Retirees and their Dependent Spouse) is amended to provide for a Calendar Year Out-of-Pocket Maximum for non-Medicare eligible Retirees and Dependent spouses, as provided below:**

Calendar Year Out-of-Pocket Maximums for non-Medicare eligible Retirees and Dependents*	
• PPO Maximum	$2,500 per person; $5,000 per family
• Additional Non-PPO Maximum	$1,000 per person; $2,000 per family

* Excludes amounts paid for non-covered expenses.

2. **Effective January 1, 2014, the following description is added to the Medical Benefit section of the Summary Plan Description and Plan Document:**

Calendar Year Out-of-Pocket Maximum for Non-Medicare Eligible Retirees and Dependent Spouses

If you have high medical expenses and are a non-Medicare eligible Retiree or Dependent spouse, the Plan protects you and your spouse by limiting the amount you have to pay out of your own pocket. This is called a calendar year out-of-pocket (OOP) maximum. When you and your spouse reach the OOP maximum set forth in the Schedule of Benefits, in any calendar year, the Plan pays 100% of any additional covered expenses, up to any specific Plan maximums, for that covered individual for the remainder of that year.

The family OOP maximum is satisfied when one covered individual has satisfied one individual OOP maximum and either one covered individual or a combination of the remaining covered individuals of a family satisfy the remaining family OOP maximum. Once the family meets the annual OOP maximum (PPO and Non-PPO, as applicable), the Plan pays 100% of any additional covered medical expenses, up to any specific Plan maximums, for the Retiree and Dependent spouse for the remainder of that year.

Amounts paid for non-covered expenses do not count toward the Plan's calendar year out-of-pocket maximum. Medicare Eligible Retirees and Dependent spouses do not have a calendar year OOP maximum. See the notes following the Schedule of Benefits for more details or contact the Fund Office with questions.

Please see the following page for an example of "How the OOP Maximum Works."

Example: How the Out-of-Pocket Maximum Works assuming the OOP maximum is $2,500 per person and the additional Non-PPO OOP maximum is $1,000.
• **Scenario A:** Michael uses only PPO providers and pays $2,500 out of his pocket in covered medical expenses between January 1 and July 31. Provided he continues to use PPO providers, the Plan will pay 100% of most additional covered expenses he incurs for the remainder of the calendar year. • **Scenario B:** Michael uses both PPO and Non-PPO providers and incurs $2,500 in out-of-pocket expenses between January 1 and July 31. If he uses only PPO providers after July 31, the Plan will pay 100% of most covered expenses for the rest of the calendar year. However, if he uses Non-PPO providers after July 31, he will need to incur an additional $1,000 in out-of-pocket expenses before the Plan pays 100% of most covered services.

3. Effective January 1, 2014, the Schedule of Benefits for the Comprehensive Medical Benefit (Retirees and their Dependent Spouse) is amended to provide for a new Calendar Year Plan Maximum for Chiropractic Care, as follows:

Comprehensive Medical Benefit (Retirees and their Dependent Spouse)	
Calendar Year Plan Maximums	
• Chiropractic Care	12 visits per person

4. Effective January 1, 2014, the Schedule of Benefits for the Comprehensive Medical Benefit (Retirees and their Dependent Spouse) is amended to clarify the co-insurance amount for Chiropractic Care, as follows:

Comprehensive Medical Benefit (Retirees and their Dependent Spouse)		
Type of Service	**PPO Provider**	**Non-PPO Provider**
• Chiropractic Care[4]	Plan pays 70% for up to 12 visits per person per calendar year	Plan pays 70% for up to 12 visits per person per calendar year

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

5. Effective January 1, 2014, the Schedule of Benefits for the Comprehensive Medical Benefit (Retirees and their Dependent Spouse) is amended to provide for a new Calendar Year Plan Maximum for Rehabilitative Physical Therapy, as follows:

Comprehensive Medical Benefit (Retirees and their Dependent Spouse)	
Calendar Year Plan Maximums	
• Rehabilitative Physical Therapy	20 visits per person[4]

[4] Rehabilitative Physical Therapy will be approved in excess of the Calendar Year Plan Maximum if approved in advance by pre-certification, case management, and utilization review. To ensure you receive the maximum benefits available under the Plan, you should ask your Physician to contact MCM prior to receiving treatment.

6. Effective July 1, 2013, the Definitions section is amended to change the definition of Dependent, as follows:

Dependent	For purposes of the Plan a Dependent is the opposite sex spouse of a Retiree who is not divorced or legally separated from the Retiree.

7. Effective July 1, 2013, the following language is added to the end of the Coordination of Benefits section:

Individual Policies of Insurance

In the event that Participants or their Dependent spouses are covered by an individual policy of insurance not purchased through a federal or state exchange and not a group medical plan as defined in this section, reimbursement under the Plan will not exceed 100% of the expenses billed, taking into account any amounts payable from such individual policy of insurance where there is no coordination of benefits.

8. Effective July 1, 2013, Covered Medical Expenses section is amended to clarify the scope of preventive health services required to be covered by the Affordable Care Act, as follows:

- Preventive Services as required by the Affordable Care Act, including well adult care, routine physical exams, mammograms and colon cancer screenings. For an up-to-date list of Preventive Services covered by the Plan, please contact the Fund Office or visit https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1
  - If a Preventive Service item is billed separately from an office visit, the Plan will impose cost sharing with respect to the office visit. If such services are not billed separately, then whether or not the Plan imposes a co-payment for the office visit will depend on if the primary reason for the visit was the delivery of the Preventive Service.

- PPO-covered provider restrictions apply to all preventive services as stated on the Schedule of Benefits (with the exception of breast pumps for the purpose of breastfeeding, which do not have to be purchased through a PPO-covered provider). The Plan will reimburse 100% of the cost of a reasonably priced electric breast pump, up to the Reasonable and Customary amount, for the purpose of breastfeeding, but not all breast pump models are required to be covered. As of July 1, 2013, the Reasonable and Customary amount allowable for breast pump coverage is $275. Please verify coverage of a particular model with the Plan and the current Reasonable and Customary amount allowable prior to your purchase.
- The Plan is permitted to use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent not specified in the recommendation or guideline.