AUTOMOBILE MECHANICS' LOCAL 701 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 **Classic Bargained** plan as documented in the applicable combination Summary Plan Description and Plan Document ("SPD" or "Plan") that was previously provided to you. Each change is summarized below and is effective as of the date noted below.

1. Retroactive to January 1, 2016, the Plan's provisions regarding reinstatement of active coverage was amended, as described below.

2. Effective July 13, 2017, Plan participants can elect to drop any of their dependents from their coverage on a one-time basis if certain conditions are met, as discussed below. Dropped dependents can also have their coverage reinstated on a one-time basis if certain conditions are met, as detailed below.

3. Effective July 13, 2017, the Plan's coordination of benefits rules (which apply when an individual is covered by more than one health plan) were modified, as discussed below.

4. Effective July 13, 2017, the Plan was amended to reflect its existing administrative practice of covering diabetic testing supplies and syringes without cost-sharing under its prescription drug benefit coverage.

5. Effective July 13, 2017, the Plan was amended to remove an exclusion related to inpatient substance abuse treatment, as discussed below.

6. Effective December 15, 2017, the Plan was amended to reflect its actual administrative practice regarding prescription drug benefit cost-sharing, as detailed below.

7. Effective January 1, 2018, the Trustees adjusted the prescription drug out-of-pocket maximum amounts for each plan design so that the combined out-of-pocket maximum amounts for major medical and prescription drug benefits equal the maximum amounts permitted under the Affordable Care Act (ACA), as described in more detail below.

8. Effective January 1, 2018, the Trustees amended the Plan's claims and appeals procedures applicable to disability claims to comply with applicable law, as described below.

9. Effective January 1, 2018, the Plan's coverage regarding "dispense as written" prescriptions was amended, as described below.

10. Effective January 1, 2018, the Plan engaged IPC/Evergreen Rx to be its case manager for certain specialty drugs. The implications of this change are discussed below.

SUMMARY OF MATERIAL MODIFICATIONS

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 (708) 482-0110 ~ Toll Free (800) 704-6270.

1. Retroactive amendment of coverage reinstatement provisions

Retroactive to January 1, 2016, the Plan was amended to provide that if your active coverage ends, and you do not continue your coverage by making COBRA payments, your active coverage will be reinstated when you meet the Plan's initial eligibility requirements (e.g., for new employees), as set forth in the SPD.

However, after your active coverage ends, if you continue your coverage by making COBRA payments, your active coverage will be immediately reinstated when you meet the Plan's continuing eligibility requirements (i.e., if and when a contributing employer makes contributions on your behalf during the week immediately following the week in which your COBRA ends, your active coverage will be immediately reinstated), as set forth in the SPD.

2. Option to affirmatively drop dependents on a one-time basis

Effective July 13, 2017, you will be able to make a one-time election to drop your covered dependents from your coverage. In order for your election to be effective, the dependent that you wish to drop from coverage must provide (1) written approval of your decision to drop him/her from your coverage; and (2) proof of alternative coverage, such as under another group health plan (e.g., a plan provided by an employer), individual plan, or under a governmental program (e.g., Medicare or TRICARE). Your election to drop your dependent from your coverage will be effective immediately once the Fund Office receives the items listed in (1) and (2) in the previous sentence.

If you previously dropped a dependent from your coverage, you may reinstate coverage for that dependent only if s/he loses medical coverage under another plan and remains eligible for coverage under this Plan. In order to reinstate coverage for your dependent, you must provide written notice to the Fund office of the loss of your dependent's other coverage within 63 days after the loss of coverage was effective. In addition, your dependent must provide the following items to be reinstated: (1) proof that s/he was covered under and subsequently lost other coverage, including the date on which the other coverage terminated; and (2) written approval of coverage reinstatement under this Plan. Your dependent's coverage will be reinstated as of the first day of the month following the date that the Fund Office receives the items described in the previous sentence. Once you have reinstated your dependent's coverage, you may not thereafter drop your dependent from your coverage again.

3. Change to the Plan's coordination of benefits rules

In situations where an individual is covered by more than one plan, the coordination of benefits rules determine which plan pays first, and which plan pays second. Effective July 13, 2017, the Plan's coordination of benefits rules were modified to state that when an individual is covered as a dependent spouse of an employee by one plan, and a dependent child of an employee by another plan, the plan covering the individual as a dependent spouse pays first.

4. Clarification regarding Plan's coverage of diabetic supplies and syringes

Effective July 13, 2017, the Trustees amended the SPD to reflect the Plan's long-standing administrative practice of covering diabetic supplies and syringes without cost-sharing (i.e., at 100%) under its prescription drug benefit.

5. Removal of inpatient substance abuse treatment-related exclusion

Effective July 13, 2017, the Trustees removed an exclusion stating that the Plan will not cover any inpatient course of treatment that is terminated without the recommendation or approval of a physician. The Plan will no longer deny coverage for an inpatient substance abuse treatment solely on this basis.

6. Clarification regarding the Plan's prescription drug benefit cost-sharing

Effective December 15, 2017, the Plan was amended to reflect its actual administrative practice regarding its prescription drug benefit cost-sharing as follows:

Prescription Drug Benefits (Active Employees and their Dependents)			
Mail Order Service or Walgreens Retail Pharmacies (preferred after two fills)	**For ~~1-~~ up to a 30-day supply, you pay:**	**~~For 31-60 day supply, you pay:~~**	**For ~~61-~~ up to a 90-day supply, you pay:**
• Generic Medication	25% ($5 minimum/$20 maximum) at Walgreens Not available through mail order	~~25% ($10 minimum/$40 maximum)~~	25% ($15 minimum/$60 maximum) at Walgreens or through mail order
• Preferred Brand Drug	30% ($25 minimum/$100 maximum) at Walgreens Not available through mail order	~~30% ($50 minimum/$200 maximum)~~	30% ($75 minimum/$300 maximum) at Walgreens or through mail order
• Non-Preferred Brand Drug	35% ($31.25 minimum/$125 maximum) at Walgreens Not available through mail order	~~35% ($62.50 minimum/$250 maximum)~~	35% ($93.75 minimum/$375 maximum) at Walgreens or through mail order

Specifically, the SPD was amended to reflect the following changes:

- Thirty-day fills are only available at their lower copays (indicated above) at Walgreens stores. Mail order fills will be assessed the 90-day copays regardless of the fill amount. This change does not impact your ability to obtain your first two fills (counted from February 1, 2017) at a retail store other than Walgreens at the copays reflected above.

- A 31-60 day fill will be assessed the copay for a 90-day fill irrespective of whether it is obtained at Walgreens or through mail order.

7. Changes to the Plan's prescription drug out-of-pocket maximum amounts

Effective January 1, 2018, the Trustees adjusted the calendar year out-of-pocket maximum amounts for prescription drugs in each plan design so that the combined out-of-pocket maximum amounts for major medical and prescription drug benefits equal the maximum amounts permitted under the Affordable Care Act (ACA). The out-of-pocket maximum amounts for major medical benefits remained unchanged. When you and/or family reach the out-of-pocket maximum amount for either major medical or prescription drug benefits during a calendar year, the Plan pays 100% of the additional covered expenses for that calendar year, up to any applicable Plan maximums.

Effective January 1, 2018, the applicable out-of-pocket maximum amounts are as follows:

Comprehensive Medical Benefit (Active Employees and their Dependents)	
Calendar Year Out-of-Pocket Maximums*	
PPO Maximum	
– Major Medical	• $5,000 per person; $10,000 per family
– Prescription Drug†	• ~~$2,150~~$2,350 per person; ~~$4,300~~$4,700 per family

8. Changes to the Plan's internal claims and appeals procedures for disability claims

Effective January 1, 2018, the Trustees amended the Plan's claims and appeals procedures applicable to disability claims. The specific changes, as detailed below, pertain to the information you will receive if your claim or appeal is denied, and your rights in the event that the Plan fails to adhere to its own claims and appeals procedures. Reproduced below are the affected portions of the SPD section titled "Filing and Appealing Claims" with the changes highlighted:

Filing Claims

If a Claim Is Denied

When you are notified of an initial denial of your claim, the notice will include:

- Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). ~~Upon request~~, and a notice that you have the right to receive, upon request, any documents relevant to the adjudication of your claim, including ~~the Plan will provide~~ the diagnosis code(s) and its corresponding meaning, and the treatment code(s) and its corresponding meaning;

- The specific reason(s) for the determination, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;

- Reference to the Plan provision(s) on which the determination was based;

- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;

- A copy of the Plan's internal claims review procedures, and external review processes, along with the time limits and information regarding how to initiate an appeal of your claim;

- A statement of your right to bring a lawsuit under ERISA §502(a) following the denial of a claim;

- If your claim is denied based on:
  - Any rule, guideline, protocol, or similar criteria, ~~a statement that~~ a copy of the rule, guideline, protocol, or similar criteria ~~is available to you, at no cost, upon request~~, or a statement that such a rule, guideline, protocol, or similar criteria does not exist; or
  - Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment or exclusion or limit is available to you, at no cost, upon request.

- If your appeal is due to the denial of an urgent care claim, a description of the expedited review process;

- If your disability claim is denied, a discussion of the decision, including the basis for disagreeing with any disability determination made by the Social Security Administration (SSA), if applicable, your treating physician, or vocational professional who evaluated you, to the extent that the Plan's decision does not follow their determinations; and

- A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

Appeal Determination Notice

When you are notified of a determination on your appeal, the notice will include:

- Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). ~~Upon request~~, and a notice that you have the right to receive, upon request, any documents relevant to the adjudication of your claim, including ~~the Plan will provide~~ the diagnosis code(s) and its corresponding meaning, and the treatment code(s) and its corresponding meaning;

- A statement that you and the Plan may have other voluntary alternative dispute resolution options, such as mediation; one way to find out what may be available is to contact your local U. S. Department of Labor Office and your state insurance regulatory agency;

- A statement explaining the external review process, along with any time limits and information regarding how to initiate the external review of your claim;

- A statement that you have a right to bring a civil action under ERISA §502(a) following the denial of your claim;

- The specific reason(s) for the determination, including the denial code and its corresponding meaning, and a discussion of the decision, as well as any Plan standards used in denying the claim;

- Reference to the Plan provision(s) on which the determination was based;

- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

- If your claim is denied based on:
  - Any rule, guideline, protocol, or similar criteria, a statement that a copy of the rule, guideline, protocol, or similar criteria is available to you, at no cost, upon request, or that such a rule, guideline, protocol, or similar criteria do not exist; or
  - Medical Necessity, Experimental Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that a copy of the scientific or clinical judgment is available to you at no cost upon request.

- If your disability claim is denied, a discussion of the decision, including the basis for disagreeing with any disability determination made by the Social Security Administration (SSA), if applicable, your treating physician, or vocational professional who evaluated you, to the extent that the Plan's decision does not follow their determinations;

- A description of the Plan's internal limitations period within which you must file a lawsuit challenging the denial of your appeal, if you choose to do so (this period is two years from the date your appeal is denied); and

- A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

Medical ~~Judgments~~ or Vocational Experts

If your claim or appeal is denied on the basis of a ~~medical~~ judgment made by a medical or vocational professional, the Plan will consult with a ~~health care~~ professional who:

- Has appropriate training and experience in the field of medicine or vocation ~~involved in the medical judgment~~ pertaining to your claim; and

- In the case of an appeal, ~~W~~was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity and views of any medical and vocational experts consulted in making a determination of your ~~appeal~~ claim. If the Plan's decision disagrees with the views of the experts consulted in connection with your claim or appeal, you will also be provided with the basis for disagreement.

Deemed Exhaustion

If the Plan Administrator fails to adhere to the claims and appeals procedures set forth herein, you are deemed to have exhausted the Plan's claims and appeals procedures, and may initiate external review of your claim (as provided above), or file a legal action regarding your claim, unless the Plan Administrator's violation(s) of its claims and appeals procedures are (1) *de minimis*; (2) non-prejudicial to you i.e., the violation(s) do not cause, and are not likely to cause, prejudice or harm to you (the claimant); ~~. The Plan's violation(s) of its claims and appeals procedures are considered *de minimis* if the Plan demonstrates that the violation(s)~~ (~~1~~3) were for due cause, or due to matters beyond the Plan's control~~; and~~ (~~2~~4) occurred in the context of an ongoing, good faith exchange of information with you; and (5) not reflective of a pattern or practice of non-compliance by the Plan. You may request a written explanation of the violation(s), which we will provide you within ten (10) days of your request. Such written

explanation will include a specific description of the Plan's basis, if any, for asserting that the violation(s) should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or court of law rejects your request for immediate review on the basis that the Plan has met the standards for the ~~*de-minimis*~~ exception described above, you have the right to re-submit and pursue the claim pursuant to the Plan's internal claims and appeals procedures. The Plan will provide you with notice regarding the opportunity to re-submit your claim. Your time period for re-submitting the claim will begin to run upon your receipt of such notice.

9. Change to Plan's rules regarding "dispense as written" prescriptions

Effective January 1, 2018, if you or your doctor request a brand name medication when a generic is available, you will be responsible for paying the applicable brand drug copayment plus the difference in cost between the brand drug and the generic drug. Prior to January 1, 2018, you were only responsible for the cost differential between the brand drug and generic drug if the brand drug was requested by you.

10. Implications regarding the Plan's engagement of IPC/Evergreen Rx as its specialty drug case manager

Effective January 1, 2018, the Plan contracted with IPC/Evergreen Rx to be its specialty drug case manager. IPC/Evergreen Rx has designated specific specialty drugs for copay assistance. These designated drugs are subject to a higher copay, specifically 30% of the drug cost. However, IPC/Evergreen Rx works with drug manufacturers to reduce the costs of these designated drugs such that you will not be responsible for paying most, if not all, of the additional copay amount.

If copay assistance is not available for a specialty drug, its cost defaults to that of the drug category it falls under (e.g., preferred brand medication), as shown in the Schedule of Benefits in the SPD. In any event, you will not pay more out-of-pocket than you would under the current copay structure. Any copay assistance you receive will not apply to any deductible or calendar year out-of-pocket maximum amounts.

Please contact IPC/Evergreen Rx at 636-614-1344 for more information, and to see whether your specialty drug(s) has been designated for copay assistance.