

**Automobile Mechanics' Local No. 701
Union and Industry Welfare Fund**

**SUMMARY PLAN DESCRIPTION AND PLAN
DOCUMENT – HRA FOR MEDICARE ELIGIBLE
RETIREES**

Dear Participant:

We are pleased to provide you with this new combination Plan Document and Summary Plan Description (Plan/SPD) booklet, which describes the HRA for Medicare Eligible Retirees (“the Plan”) for Automobile Mechanics’ Local No. 701 Union and Industry Welfare Fund (“the Fund”) as of April 1, 2015.

The Plan offers a health reimbursement account (“HRA”) which you can use to purchase a Medicare supplement plan on a private exchange utilized by the Fund. The Fund provides contributions to your HRA, which you may use to help pay for a Medicare supplement plan and to receive reimbursements of other qualified medical expenses. The Fund has contracted with Extend Health to provide a variety of Medicare supplement plans and to administer reimbursements of qualified medical expenses.

We have tried to describe the HRA as completely as possible in everyday language. We also organized the Plan/SPD to be useful to you. Please read this booklet carefully as it is important that you understand your HRA benefit. If you are married, be sure to share it with your spouse. When you select your own Medicare supplement plan through Extend Health, the insurance carrier will provide you additional materials concerning the benefits that are payable under the policy you have selected.

This Plan/SPD replaces and supersedes all booklets and/or certificates pertaining to benefits under the Union and Industry Welfare Fund that may have been issued previously. The Plan may be amended from time to time—either to revise the benefits or to bring the Plan into compliance with changes in the laws. If this occurs, you will be provided with written notification explaining the change(s).

We recommend that you keep this Plan/SPD with your important papers so you can refer to it when needed. If you have any questions about this booklet or the benefits offered under the Plan, please contact the Fund Office.

Sincerely,

Union Trustees

Armando Arreola
Sam Cicinelli
Robert Keppler

Employer Trustees

Ronald Fetty
Chris Konecki
Dave Mashek

The Board of Trustees has sole authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Board. Benefits under this Plan will be paid only if and when the Board of Trustees, or persons to whom such decision-making authority has been delegated by the Board, in their sole discretion, decides the participant or beneficiary is entitled to benefits under the terms of the Plan. The decisions of the Board in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If the Plan makes inadvertent, mistaken, excessive, erroneous, or fraudulent payment of benefits, the Trustees or their representative will have the right to recover these types of payments. The Board of Trustees reserves the right to change, modify, or discontinue all or part of the benefits in this booklet at any time by action or amendment.

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Plan Document and Summary Plan Description HRA For Medicare Eligible Retirees Effective April 1, 2015

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Important Contact Information

If you have a question about:	Contact:
Eligibility for benefits or general questions about your benefits	Fund Office 1-708-482-0110 or toll-free at 1-800-704-6270 www.mech701-benefits.org
How to enroll in a Medicare supplement plan offered by Extend Health	[TBD: What is Extend Health's preferred contact information?]
How to receive reimbursements for qualified medical expenses through Extend Health	[TBD: What is Extend Health's preferred contact information?]
Benefits under your Medicare supplement plan	When you sign up for a Medicare supplement plan through Extend Health, the insurance carrier you have chosen will provide you with additional benefit and contact information. Benefit claims under your Medicare supplement plan will be administered by your insurance carrier.

Change of Address and Change in Family Status

Most information about the Plan is sent to you by mail. If you move, please notify the Fund Office in writing of your address change. Failure to do so may jeopardize your eligibility or benefits because we have no way to contact you about Plan changes.

Additionally, it is very important that you notify the Fund Office immediately if you have a change in family status, such adding a Dependent through marriage, or in the event you and your spouse legally separate or become divorced. The Plan requirements for notifying the Fund Office of a change in family status are explained in more detail in the applicable eligibility sections below.

HRA Eligibility

The following sections contain the Plan's eligibility rules for Medicare-eligible Retirees and their Medicare-eligible Dependent spouses. Retirees and Dependent spouses who are not yet eligible for Medicare are not eligible to participate in this Plan, but may participate in the Fund's Retiree Plan for pre-Medicare eligible Retirees. Children of Retirees are not eligible as a Dependent under the Plan. Retirees and their Dependent spouses are eligible for benefits under the Plan as of the date the conditions in the following sections are met.

To receive HRA Benefits, you and your Dependent spouse must follow the instructions in the "Enrollment Guide" which is provided by Extend Health. The Enrollment Guide provides further instructions on how to enroll in the Plan and how to choose a Medicare supplement plan that is right for you.

Retired Employee Eligibility

Transition from Pre-Medicare Retiree Plan to This Plan

If you are a participant in the Retiree Plan for pre-Medicare eligible Retirees or any other retiree health and welfare benefit offered by the Trustees, including a pre-Medicare retiree HRA, then you will be automatically transitioned to this Plan when you become eligible for Medicare. Before you become eligible for Medicare, you will receive notice concerning your eligibility for this Plan and will be given an opportunity to opt-out. If you do not opt-out, your eligibility for an HRA benefit under this Plan will begin on the first day of the month after you become eligible for Medicare (but no earlier than April 1, 2014), and your eligibility under the pre-Medicare eligible Retiree Plan will cease.

If you Retire after you are Eligible for Medicare

If you are eligible for Medicare when you retire, you may be eligible for HRA Benefits if you meet the following requirements:

- You were a collectively bargained participant in a welfare plan offered under the Automobile Mechanics' Local 701 Union and Industry Welfare Fund (as of April 1, 2014, this includes the Premier Plus, Premier and Classic Bargained Plans); or
- You were the Fund Administrator, Assistant Fund Administrator, Fund Office staff, or business agent of Mechanics Union Local #701 (the "Union"); and
- You meet one of the two following years of coverage requirements:

- You are eligible for an immediate, early, disability or normal retirement benefit from the Local 701 Pension Fund or the IAM National Pension Fund and have at least 10 years of eligibility in the Local 701 Welfare Fund with coverage in all of the 5 years immediately prior to retirement. A participant will be considered to have had coverage in all of the 5 years immediately prior to retirement if he had at least 20 weeks of Covered Employment during each of such years; or
 - You are at least age 55 and have 20 years of eligibility as a participant in the Local 701 Welfare Fund.
- You file a written application for HRA Benefits and you enroll in a Medicare supplement plan with Extend Health within 90 days of the date your eligibility for Active Employee Benefits under the Fund ends.

If you meet all of the conditions listed above, your eligibility for HRA Benefits will begin on the first day of the month after your coverage as an Active Employee ends under the Premier Plus, Premier or Classic Bargained Plan of Benefits; provided that you submit your application within the 90-day timeframe stated above. **If you do not file your application within the 90-day timeframe, you will lose your eligibility for HRA Benefits, with no possibility of reinstatement.**

Return to Work

If you return to work for an Employer in Covered Employment, your eligibility for an HRA benefit will cease once you meet the initial eligibility requirements for Active Employee Benefits. **However, when you re-retire, you must submit an application for HRA Benefits and enroll with Extend Health within 90 days of your Active Employee coverage ending or you will not be eligible for HRA Benefits.**

When Retiree Coverage Ends

Generally, your HRA Benefits end when the first of the following events occurs:

- You provide notice that you are opting out of the Plan;
- You are no longer enrolled in a Medicare supplement plan provided by Extend Health that includes hospital insurance and medical insurance;
- The Trustees terminate HRA Benefits;
- The Trustees terminate the Plan; or
- Your death.

There is no reinstatement of Retiree coverage if you decide to opt-out of the Plan or if you decide to utilize a Medicare supplement plan outside the Extend Health network. Additionally, the above listed events are not considered qualifying events as defined in COBRA. Accordingly, when your coverage ends due to one of the above listed events, you and your Dependent

spouse will not receive or be eligible for COBRA continuation coverage unless the loss of coverage is due to your death.

Dependent Eligibility

[Children of Retirees and individuals who are not eligible for Medicare are not eligible for Retiree HRA Benefits under the Plan.](#)

Eligibility for Your Dependent Spouse

If you are covered under a plan offered by the Fund at the time your Dependent spouse becomes eligible for Medicare, he or she will be eligible for an HRA benefit under this Plan as follows:

If Your Dependent Spouse Becomes Medicare Eligible Before You Become Medicare Eligible. If your spouse is a covered Dependent in the Retiree Plan for pre-Medicare eligible Retirees or any other retiree health and welfare benefit offered by the Trustees, including a pre-Medicare retiree HRA, your spouse will be automatically transitioned to this Plan when your spouse becomes eligible for Medicare. Before your spouse becomes eligible for Medicare, your spouse will receive notice concerning his or her eligibility for this Plan and will be given an opportunity to opt-out. If your spouse does not opt-out, your spouse's eligibility for an HRA benefit under this Plan will begin on the first day of the month after your spouse becomes eligible for Medicare (but no earlier than April 1, 2014), and your spouse's eligibility under the pre-Medicare eligible Retiree Plan will cease.

If Your Dependent Spouse Becomes Medicare Eligible After You Become Medicare Eligible. If your spouse is not eligible for Medicare when you retire, but is a covered Dependent in the Retiree Plan for pre-Medicare eligible Retirees and becomes eligible for Medicare, then your spouse will be automatically transitioned to this Plan when he or she becomes eligible for Medicare. Before your spouse becomes eligible for Medicare, your spouse will receive notice concerning eligibility for this Plan and will be given an opportunity to opt-out. If your spouse does not opt-out, your spouse's eligibility for an HRA benefit under this Plan will begin on the first day of the month after your spouse becomes eligible for Medicare and becomes enrolled in a Medicare supplement plan offered by Extend Health (but no earlier than April 1, 2014), and your spouse's eligibility under the pre-Medicare eligible Retiree Plan will cease.

If you marry after you elect HRA Benefits and your new spouse is eligible for Medicare, you may submit a registered marriage license (with the state's registration number), and a copy of your spouse's social security card and new history card to the Fund Office to elect coverage for your new spouse and your spouse will be enrolled in a Medicare supplement plan with Extend Health. However, you must notify the Fund Office and submit the required documentation within 90 days of the date your Dependent spouse first becomes eligible under the Plan to receive coverage as of that date. If you do not provide the required documentation and have

your spouse enroll in a Medicare supplement plan offered by Extend Health within this 90-day period, coverage will begin as of the date the documentation is submitted to the Fund Office.

When Dependent Spouse Coverage Ends

Your Dependent spouse's HRA Benefits end upon the earliest of the following events:

- Your Dependent spouse provides notice that he or she is opting out of the Plan;
- Your Dependent spouse is no longer enrolled in a Medicare supplement plan offered by Extend Health that includes hospital insurance and medical insurance;
- You are living and no longer covered under a plan offered by the Fund;
- The Trustees discontinue HRA Benefits for Dependent spouses;
- The Trustees terminate the Plan;
- The death of your Dependent spouse; or
- You legally separate or divorce from your Dependent spouse.

If Coverage Ends Due to Divorce or Legal Separation

If you and your spouse legally separate or divorce, your spouse's loss of coverage is considered a qualifying event as defined under COBRA; however, you must notify the Fund Office within 60 days of a court entry approving or finalizing the legal separation or divorce. Failure to do so may result in: (1) the loss of COBRA rights, (2) the Fund withholding future benefits and/or (3) the Fund seeking repayment of benefits paid on behalf of an ineligible individual.

Continued Spousal Coverage Upon Your Death

If you die while you are covered under the Fund as a Retiree, HRA Benefits for your Dependent spouse will continue until he or she remarries. This coverage is in lieu of COBRA coverage and an election to continue receiving HRA Benefits under the Plan will constitute a waiver of COBRA coverage. Therefore, if your Dependent spouse elects to continue coverage under this provision, once he or she loses eligibility, COBRA continuation coverage is not available.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), is a federal law that requires plans to offer a temporary extension of benefits to employees and eligible dependents (qualified beneficiaries) who would otherwise lose coverage under a plan. Qualified beneficiaries under this Plan include your Dependent spouse who would lose coverage as a result of a qualifying event (here, your divorce or legal separation).

If you and your Dependent spouse legally separate or divorce, he or she may continue to receive reimbursements from the HRA, but the Fund subsidies will stop as of the date of the

divorce or legal separation. Additionally, he or she will be required to make a self-payment to the Plan to continue to receive reimbursements from the Plan. In the event of your divorce, additional COBRA information will be provided to your Dependent spouse.

HRA Benefits

The Health Reimbursement Account (HRA) is designed fund a portion of the monthly premium required for a Medicare supplement plan offered by Extend Health, or to reimburse Retirees and Dependent spouses for qualified medical expenses under §213 of the Internal Revenue Code incurred by themselves, or on behalf of their Dependents, tax free.

HRA Account Set Up and Funding

In April 2014, the Fund will create HRA accounts on behalf of all Medicare-eligible Retirees and Medicare-eligible Dependent spouses who are eligible for and are covered by this Plan. The Fund will deposit an initial lump sum payment of \$500 per Medicare-eligible Retiree and \$500 per Medicare-eligible Dependent spouse into these accounts during April 2014 to offset any deductibles that may have paid from January 1 to March 30, 2014. In addition, beginning April 2014, Medicare-eligible Retirees and Medicare-eligible Dependent spouses who are eligible for and are covered by this Plan will each receive a monthly deposit into their HRA accounts from the Fund. As of April 1, 2014, the contribution amounts are \$51/month for the Retiree and \$51/month for the Dependent spouse. HRA contributions will cease as soon as you or your Dependent spouse are no longer eligible for HRA Benefits. HRA contribution amounts may be revised by the Board of Trustees at any time.

HRA Highlights

Once you have enrolled in a Medicare supplement plan with Extend Health that includes hospital insurance and medical insurance, you can utilize contribution credits in your individual HRA accounts to cover specified expenses that have been incurred by you or your Dependent spouse. Covered expenses include only the premium costs for coverage under a Medicare supplement plan offered through Extend Health, or other qualified medical expenses under §213 of the Internal Revenue Code. You may not receive cash from your HRA account under any other circumstances.

An HRA is not a savings account. You may not deposit money in it or withdraw money from it and you do not receive interest or earnings on it. Your HRA account is an unfunded bookkeeping account. When the Fund makes contributions for your HRA, it is not a vested benefit and the Trustees reserve the right to discontinue contributions to or benefits from your HRA at any time.

Your HRA

Your HRA Balance

- Your HRA balance is the total of Fund HRA contributions made on your behalf while you and/or your Dependent spouse are eligible to participate in the Plan minus the reimbursements provided by the HRA. You will not receive interest or earnings on your HRA account.
- If Extend Health issues you an HRA reimbursement check for an Eligible Expense, your HRA account balance will be reduced by the amount of such reimbursement. Any remaining balance at the end of a calendar year is carried forward from year to year, except as specified below.

Expenses Eligible for Reimbursement

Your HRA is used primarily to pay for a portion of the monthly premium for a Medicare supplement plan offered by Extend Health. This is one type of Eligible Expense.

Eligible Expenses also include “qualified medical expenses” under Section 213(d) of the Internal Revenue Code that you and/or your Dependent spouse incur provided that the expense is:

- Incurred on or after April 1, 2014, or the first day you are covered under the Plan, whichever is later;
- Incurred while you and/or your Dependent spouse were eligible for HRA Benefits or while your Dependent spouse was eligible for COBRA continuation coverage (provided your Dependent spouse was eligible for HRA Benefits prior to becoming covered under COBRA);
- One that you or your Dependent spouse are required to pay or have already paid;
- Not taken as a tax deduction; and
- Not reimbursed or payable by another source.

For a complete list of eligible expenses, please see Publication 502 as prepared by the Internal Revenue Service and materials provided by Extend Health. Common examples of eligible expenses include the following:

- Payments for coverage under a Medicare supplement plan offered through Extend Health.
- Out-of-pocket Plan costs, such as deductibles, copayments, and coinsurance.

- Healthcare expenses not covered, or only partially covered, under your Medicare supplement Plan, such as LASIK surgery or orthodontia and expenses that exceed benefit maximums.
- Eye surgery, including laser eye surgery (e.g., cataracts, radial keratotomy, etc.)
- Smoking-cessation programs, including prescribed medications designed to help with stopping smoking.
- Massage therapy provided by a state licensed massage therapist.
- Premiums paid for disability, or long-term care insurance.

Expenses not Eligible

Payments for coverage under a Medicare supplement plan that is not offered through Extend Health are not available for reimbursement under this Plan. Additionally, any expense for an item that does not constitute "medical care," as defined in Internal Revenue Code §213 is not eligible for reimbursement or payment from your HRA. Common expenses that are not eligible for reimbursement from the HRA include, but are not limited to:

- Automobile insurance.
- Bottled water.
- Controlled substances (such as marijuana) that are in violation of federal laws.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal injury resulting from an accident or trauma, or disfiguring disease. Cosmetic surgery means any procedure that is directed at improving the patient's appearance and does not fully promote the proper function of the body or prevent or treat illness or disease.
- Cosmetics, toiletries, toothpaste, etc.
- Custodial Care.
- Dental bleaching.
- Diapers or diaper service.
- Expenses incurred before eligible to participate in the Plan.
- Funeral or burial expenses.
- Health club or fitness program dues, even if necessary to alleviate a specific medical condition (such as obesity).

- Home or automotive improvements.
- Household and domestic help.
- Long-term care services.
- Nurse expenses to care for a healthy newborn at home.
- Over-the-counter items, drugs, or medications.
- Social activities (such as dance lessons).
- Transportation expenses (such as, but not limited to, transportation to receive Medical Care).
- Uniforms or special clothing (such as maternity clothing).
- Weight loss programs for general health or appearance.

Reimbursements

Reimbursements from your HRA account are subject to the following provisions:

- Claims for reimbursement must be received by Extend Health no later than one (1) year following the date on which the expense was incurred.
- You must submit an HRA reimbursement request to Extend Health utilizing the procedures as outlined in the Extend Health publication titled “Funding and Reimbursement.”
- HRA reimbursement requests may only be submitted by you or by your Dependent spouse, or in the event you are deceased, by your surviving spouse. HRA reimbursement requests may not be submitted by a former spouse (unless COBRA coverage is timely elected). Additionally, a HRA balance is not subject to division pursuant to a domestic relations order under the preemption provisions of ERISA Section 514.

Upon receipt of a HRA reimbursement request for an Eligible Expense, Extend Health will issue you a reimbursement. This reimbursement will be issued for the amount of the eligible expense, up to, but not to exceed the amount of your HRA balance. Once the reimbursement has been issued, Extend Health will deduct the amount of such reimbursement from your HRA balance. If your HRA account balance is less than the amount of your request, Extend Health will issue you a reimbursement for the amount in your HRA account at the time of the request. Any excess not reimbursed should be re-submitted with your next reimbursement request.

Forfeiture of your HRA Once Your Eligibility Terminates

Once you are no longer eligible for coverage or are no longer enrolled in a Medicare supplement plan offered by Extend Health, any unused balance in your HRA will be permanently forfeited if at any time you have not been eligible for coverage for a 12-month period and your account is inactive (no contributions or claims) for a 12-month period. Any forfeited amounts revert to the Plan's general assets and are used for administrative expenses. In no event will permanently forfeited amounts be paid in cash to any person.

Your HRA In the Event of Your Death

If you die and there is a balance in your HRA account, your surviving spouse may use your account balance provided that they continue to be eligible for HRA Benefits and remain enrolled in a Medicare supplement plan offered by Extend Health. Any remaining HRA account balance not reimbursed to your surviving spouse upon his or her death will be forfeited. Your HRA balance is Trust Fund property, is not inheritable and will not become part of your estate.

Filing and Appealing Claims

Filing Claims

To ensure prompt processing of your claims, please follow the claim submission guidelines indicated. All claims must be submitted to the Fund no later than one year from the date the expenses were incurred. No benefits will be paid on claims submitted after the one-year period.

What is a Claim

A claim for benefits is a request for Plan benefits that you make in accordance with the Fund's reasonable claims procedures. There are three categories of claims you should be aware of:

- Eligibility. You or your Dependent spouse may claim that you are eligible for HRA Benefits under the Plan.
- Reimbursements of Qualified Medical Expenses. You or your Dependent spouse may claim that a particular medical expense that you incurred should be reimbursed by the HRA.
- Health Benefit Claims Under Your Medicare Supplement Plan. You or your Dependent spouse may have claims for medical and prescription drug expenses under your Medicare Supplement plan. **PLEASE NOTE: All claims for medical and prescription drug expenses under your Medicare Supplement plan must be submitted to the insurance carrier that you have chosen, using your carrier's benefit claims procedures. This Plan only provides an HRA Benefit, which reimburses you for a portion of the cost of your Medicare Supplement plan or other qualified medical expenses. Therefore, this Plan is not responsible for and does not administer claims for the medical and prescription drug expenses under your Medicare Supplement plan.**

If you make a simple inquiry about the Plan's provisions without a claim form, the Fund will not treat your inquiry as a claim for benefits.

How to File Claims for HRA Benefits

- Initially, all claims for eligibility or for reimbursements of HRA Benefits must be submitted to Extend Health.
- Further information concerning the submission of claims to Extend Health is provided in a publication from Extend Health titled "Funding and Reimbursement." You should read the information provided in this publication carefully and following the instructions provided by Extend Health.

- Initial claims are administered by Extend Health, and appeals are decided by the Board of Trustees, under the procedures and timeframes required by the Department of Labor Regulations at 2560.503-1. These legal requirements are set forth in further detail below.

Claim Determinations

When you submit a claim for benefits, the claims administrator will determine if you are eligible for benefits and calculate the amount of benefits, if any. All claims are processed promptly and will be paid as soon as administratively possible, when complete claim information is received. You will be notified of an initial determination within certain timeframes. If circumstances require an extension of time for making a determination on your claim, you will be notified, in writing, that an extension is necessary. The notice will state the special circumstances and the date a determination is expected.

If you make a claim for eligibility, a subsidy, or for the reimbursement of HRA benefits, an initial determination will be made not later than 30 days from the receipt of your claim. Within this 30-day period, the Plan may notify you of an extension of time of up to 15 days to make an initial determination if there are special circumstances warranting such an extension. If an extension is necessary because you did not provide the necessary information, you will be notified of the information that is needed. You will have up to 45 days to respond. The initial deadline is suspended for 45 days or until the information is received, if sooner.

If a Claim Is Denied

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling Extend Health. If a disagreement is not resolved, there is a formal procedure you may follow to have your claim reconsidered.

If your claim is denied (in whole or in part), also referred to as an “adverse benefit determination,” you will be provided with certain information about your claim within the timeframes previously described.

A claim denial or adverse benefit determination, for purposes of the claims and appeals process, is defined as:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on:
 - A determination of an individual’s eligibility to participate in the Plan; or
 - A determination that a benefit is not a covered benefit; or
- Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

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, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code 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; and
- 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;
 - 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;
- 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.

Examples of When a Claim May Be Denied

Extend Health has the authority to make determinations on claims. Following are some examples of when a claim may be denied, or that may result in reduced benefits:

- The individual on whose behalf the claim was filed was not covered under the Plan on the date the expenses were incurred.
- The claim was not filed within the Plan time limits.
- The claim was not for qualified medical expenses covered under the Plan.

- The claim was for expenses that were not actually incurred.
- Your HRA does not have sufficient funds to reimburse the expense.
- Plan eligibility rules or benefits were amended.
- An eligible individual's future benefits were reduced or temporarily suspended to recover an overpayment of benefits previously made.
- The Plan was terminated.

This list is not all-inclusive, but rather representative of the types of circumstances, in addition to failure to meet the Plan's regular eligibility requirements for coverage under the Plan, that may cause benefits to be denied or reduced.

Appealing a Denied Claim

If your claim is denied (in whole or in part) and you receive an adverse benefit determination or you disagree with the Plan's determination regarding your eligibility for benefits or the amount of the benefit, you have the right to have the initial determination reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Board of Trustees at the address of the Fund Office as soon as possible. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within 180 days after you receive the notice of denial. Your written appeal must explain the reasons you disagree with the determination on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- Submit additional materials, including comments, statements, or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol, or other similar criteria on which the denial was based; and
- Request a copy of any explanation of the scientific or clinical judgment on which the denial was based if the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit.

Appeal Determinations

If you file your appeal on time and follow the required procedures, a new, full, and independent review of your claim will be made and the determination will not be based on the initial determination. An appropriate fiduciary of the Plan, generally the Board of Trustees, will

conduct the review and the determination will be based on all information used in the initial determination as well as any additional information submitted.

You will be notified, in writing, of the determination on your appeal no later than within the stated timeframes. However, oral notice of a determination on your urgent care claim may be provided to you sooner. After the Fund issues a final determination of your claim on appeal, you may institute legal action as described in the Trustee Authority and Interpretation Section below.

Appeal Determination Timeframes

A determination on your appeal will be made within certain timeframes. A determination will be made at the Board of Trustees' next regularly scheduled quarterly meeting following receipt of your appeal and you will receive a written determination within five days of the meeting at which the determination is made. However, if the request is filed within 30 days of the date of the meeting, the determination may be made at the second meeting following receipt of your appeal. If special circumstances require a further extension, a determination will be made at the third meeting following receipt of your Appeal. You will be notified if any extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a determination.

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, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code 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 information is available to you at no cost upon request; or
 - 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.
- 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.

Authorized Representatives

When appealing a claim, you may authorize a representative to act on your behalf. You must provide written notification authorizing this representative. The written notification must include the individual's name, address, and phone number. However, if you are unable to provide a written statement, the Plan requires other written proof (such as power of attorney for health care purposes or court order of guardian/conservator) that the proposed authorized representative has been authorized to act on the individual's behalf.

Authorized representatives may include a:

- Health care provider that has knowledge of the condition in an emergency situation;
- Legal spouse;
- Dependent child age 18 or over;
- Parent or adult sibling;
- Grandparent;
- Court-ordered representative, such as an individual with power of attorney for health care purposes, legal guardian, or conservator; or
- Other adult.

Once a representative is authorized, all future claims and appeals related correspondence will be sent to the authorized representative. The Plan will recognize the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization. However, the individual may revoke a designated authorized representative at any time by submitting a signed statement.

The Plan Administrator, or its designated representative, has the discretion to determine whether an authorized representative has been properly designated in accordance with the Plan's terms. The Plan Administrator reserves the right to withhold information from a person who claims to be an authorized representative if there is suspicion about the qualifications of that individual. Under no circumstances does the designation of a person as an "authorized representative" provide that person with any of the rights of a "participant" or "beneficiary" under this Plan.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such has decisions related to hiring, compensation, promotion, termination) or retention will not be made on the basis of whether that person is likely to support a denial of benefits.

Trustee Authority and Interpretation

The Trustees or, where Trustee responsibility has been delegated to others, such other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of this Plan, and decisions of the Trustees or their delegates are final and binding. *Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them, decide, in their discretion, that the eligible Retiree or beneficiary is entitled to benefits in accordance with the terms of the Plan.* In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure adopted by the Trustees. The decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matter.

You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the procedures described in this section. You may, at your own expense, have legal representation at any stage of the review process. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner.

The final decision on an appeal will be accorded judicial deference in any later court action or administrative proceeding to the extent that it does not constitute an abuse of discretion and is not arbitrary or capricious.

The Plan contains a two (2) year statute of limitations. Notwithstanding any other state or federal law, any and all legal actions relating to the Plan must be filed within two (2) years of the action or inaction complained of. This includes but is not limited to actions to recover benefits that must be filed within two (2) years of the final decision on your claim. The situs of

Plan is in Cook County, Illinois. Legal actions must be brought in the United States District Court for the Northern District of Illinois.

Subrogation and Reimbursement

The Plan's right of subrogation and reimbursement arises when benefits are paid on behalf of an eligible individual as a result of an accidental Injury or Illness for which another party may be responsible.

The Plan's subrogation or reimbursement rules apply if the Fund pays any benefits that arise out of an accidental Injury or Illness which results or could result in a claim against a third party. By accepting benefits under the Plan you are agreeing to reimburse the Fund for all such expenses paid on your behalf related to the accidental Injury or Illness.

Under these circumstances, the Fund is entitled to full and total reimbursement (100%) of its past, present or future expenditures related to the Injury or Illness from all third party recoveries and as such, you shall be deemed to hold the right to recovery against such party in trust for the Plan.

Third parties may include, but are not limited to: (1) any person or entity legally responsible for your Injury; (2) other benefit plans; (3) an insurance company; (4) workers' compensation; or (5) any other person or entity that is obligated to make payments which the Fund would otherwise be obligated to make.

As an eligible individual, by accepting benefits under this Plan, your responsibilities include the following:

- You and/or your Dependent spouse must immediately notify the Fund Office whenever a claim against a third party is made for yourself and/or your Dependent spouse regarding any loss for which the Fund paid benefits on your and/or your Dependent spouse's behalf.
- You and/or your Dependent spouse must cooperate with the Fund by providing information requested by the Fund concerning subrogation or reimbursement. This includes providing the Fund Office with (1) a signed subrogation and reimbursement agreement; (2) the names and addresses of all potential third parties and their insurer, adjusters and claim numbers; (3) any accident reports; and (4) any other information the Fund Office requests, including contact information of an attorney representing you in your claim against a third party.
- You and/or your Dependent spouse agree to give the Fund the right to prosecute your claim and maintain an action against the third party on your behalf.
- You and/or your Dependent spouse agree to reimburse the Fund in full for the benefits expended on your and/or your Dependent spouse's behalf related to the claim against a third party.

If you fail to meet your responsibilities, the Fund may withhold future benefit payments for both you and your Dependent spouse until you comply with these requirements.

If you and/or your Dependent spouse receive payment from a third party for benefits paid by the Fund, you or the third party must reimburse the Fund. The proceeds of the settlement or judgment must be divided as follows:

- The Plan has priority over all funds recovered. Accordingly, you or your representative must pay the Fund a sum sufficient to fully reimburse the Fund for all (100%) benefits advanced prior to satisfying any other existing lien or claims. No reductions or deductions are allowed for attorneys' fees pursuant to the "make-whole" doctrine or any other state law affecting these rights is preempted by ERISA (i.e., the common fund doctrine).
- Any remaining funds may be paid to you and/or your Dependent spouse.

The proceeds of any claim against a third party must be divided as stated above even if you and/or your Dependent spouse are not fully compensated for the loss. However, the Fund is not entitled to receive reimbursement in excess of the amount you and/or your Dependent spouse receive from all third parties.

You and your Dependent spouse (if applicable) shall be responsible for compliance with these provisions and the provisions of any subrogation and reimbursement agreement. You will also be responsible for compliance by your or your Dependent spouse's agents, representatives and attorneys.

Furthermore, if you and/or your Dependent spouse receive payment from a third party for Plan benefits already received and you do not reimburse the Fund as stated above, the Fund may take any action to recover the benefits paid. Such action includes, but is not limited to: (1) initiating a claim to compel compliance with these terms or the terms of the subrogation and reimbursement agreement; (2) withholding benefits payable to you or your Dependent spouse until you or your Dependent spouse complies; or (3) initiating such other equitable or legal action it deems appropriate.

Overpayment and Duty of Cooperation

Whenever payment(s) have been made in excess of the allowable amount under the Plan, the Fund has the right to recover such excess payments from any providers, person(s), service, plan, or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of the Retiree or Dependent spouse, the Fund, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments, or institute legal action to collect the overpayment.

Eligible individuals must provide the Fund with any information the Fund deems necessary to determine eligibility, process claims, or implement Plan terms. Failure to provide any information requested by the Fund or its agents may result in the rejection of claims for benefits.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Fund may also obtain reimbursement of interest, professional fees incurred, and other damages related to that overpayment.

Misrepresentation or Falsification of Claims

A claim for benefits will be rejected and the Fund will be entitled to recover money that an eligible individual or a service provider has received if a false statement or omission of a material fact was purposely made by any person to receive benefits. The Fund may also obtain reimbursement of interest on this money as well as professional fees incurred and other damages.

If any individual knowingly misrepresents or falsifies any information or matter in connection with a claim filed for Plan benefits, the Trustees may, in their sole discretion, deny all or part of the benefits that might otherwise be due in connection with that claim.

Wrongfully Paid Benefits

Whenever the Trustees pay benefits that exceed the amount of benefits that should be paid under the terms of this Plan, the Trustees will have the right to recover the wrongfully paid benefits from any providers, person(s), service, plan, or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of employee Retiree or Dependent spouse, the Fund, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments or institute legal action to collect the overpayment.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Plan may also obtain reimbursement of interest, professional fees incurred, and other damages related to that overpayment.

Administrative Information

This section provides information about how the Welfare Fund is administered.

Plan Name

The name of the plan is Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund – HRA for Medicare Eligible Retirees.

Board of Trustees

A Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of Union and Employer representatives selected by the local Union and the Employer Associations that have entered into Collective Bargaining Agreements that relate to the Plan. The Board of Trustees may be contacted at the following address and phone numbers:

Board of Trustees
Automobile Mechanics' Local No. 701
Union and Industry Welfare Fund
500 West Plainfield Road
Countryside, Illinois 60525
Telephone: 1-708-482-0110 or toll-free at 1-800-704-6270

The present Trustees are:

Union Trustees	Employer Trustees
Armando Arreola Automobile Mechanics' Union Local 701 450 Gundersen Drive Carol Stream, IL 60188	Ronald Fetty ABF Freight Systems 1900 East Route 30 Sauk Village, IL 60411
Sam Cicinelli Automobile Mechanics' Union Local 701 450 Gundersen Drive Carol Stream, IL 60188	Chris Konecki Chicago Automobile Trade Association 18W200 Butterfield Road Oakbrook Terrace, IL 60181
Robert Keppler Automobile Mechanics' Union Local 701 450 Gundersen Drive Carol Stream, IL 60188	Dave Mashek Prairie Material 7601 W. 79th Street Bridgeview, IL 60455

Administration of the Plan

The Board of Trustees makes the rules and regulations to administer your Plan. By amendment, the Board of Trustees may change the terms, conditions, or benefits of the Plan. Only the Board

of Trustees can make a final decision regarding any question, interpretation, or application of any part of the Plan. No employer or Union or any representative of any employer or Union, is authorized to interpret the Plan. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner, and the Trustees decisions will be awarded judicial deference. Benefits under this Plan will be paid only when the Board of Trustees (or persons delegated by the Trustees) decides, in their discretion, that the eligible individual is entitled to benefits in accordance with the Plan's terms.

The Welfare Fund employees, who are hired by the Trustees and answer to them, conduct plan administration. All rules, regulations, and policies adopted by the Trustees will be binding upon all parties to the Trust Agreement, all parties dealing with the Plan and all persons claiming benefits provided by the Plan.

The provisions of the Plan may be amended from time to time by a majority vote of the Trustees. Amendments may include increases, modifications, reductions, or the elimination, in whole or in part, of certain benefits.

Amendments to the Plan can be made for any reason and are "settlor" issues that are not subject to review for conformity with fiduciary duties. In the event of elimination, reduction, or modification of benefits you or your beneficiary may be required to pay providers for benefits that were formerly covered by the Plan. In the event of increases or other modification of benefits, you or your beneficiary may find yourself relieved of requirements to pay providers for benefits that were formerly not covered by the Plan.

Plan Termination

The Plan may be terminated under circumstances allowable under ERISA and the terms of the governing Trust Agreement. For example, this Plan may be terminated if future collective bargaining agreements and participation agreements do not require employer contributions to the Plan. Termination may be made for any reason conforming to ERISA and the terms of the Trust Agreement and is a "settlor" issue that is not subject to review for conformity with fiduciary duties.

In the event of Plan termination, the Trustees will notify the Union, Employers, and any insurance carriers and the Trustees will take necessary steps to wind down the Trust. In conformity with the provisions of the Trust Agreement, the Trustees will apply the Plan assets to pay or to provide for the payment of any and all obligations of the Plan. Benefits for covered expenses incurred before the termination date fixed by the Trustees will be paid to eligible individuals as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets.

However, any remaining surplus will, in accordance with the terms of the Trust Agreement, be used in such manner as the Trustees believe will best effectuate the purpose of the Plan, subject to the requirement that no part of the corpus may be diverted to any purpose other than the exclusive benefit of participants and beneficiaries and payment of the administrative

expenses of the Plan. Upon termination, no part of the assets of the Plan will revert or accrue, directly or indirectly, to the benefit of an Employer or the Union.

Plan Sponsor and Administrator

The Board of Trustees is both the Plan Sponsor and Plan Administrator. The Trustees have designated Steve M. Bukovac as Administrative Manager. It is the Administrative Manager's responsibility to handle the day-to-day activities of the Fund. You may contact Mr. Bukovac at the following address and phone numbers:

Automobile Mechanics' Local No. 701
Union and Industry Welfare Fund
500 West Plainfield Road
Countryside, Illinois 60525
Telephone: 1-708-482-0110 or toll-free at 1-800-704-6270

Identification Numbers

The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 36-2331071.

The Plan number is 501.

Plan Year

The records of the Plan are kept separately for each calendar year (January 1 through December 31).

Agent for Service of Legal Process

If legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees or the Administrative Manager, Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund, 500 West Plainfield Road, Countryside, Illinois 60525.

Plan Description

This Plan is a group health plan maintained for the purposes of providing medical and prescription drug benefits.

All benefits described in this booklet are self-funded by the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund.

Source of Contributions

The benefits described in this booklet are provided through a subsidy from the Fund. Employers and Employees contribute to the Fund as set forth in the applicable Collective Bargaining Agreements. The amounts of the subsidy and the individuals on whose behalf subsidy contributions are made are determined by the Board of Trustees, and the subsidy amount may be amended or terminated at any time by the Board of Trustees.

The Fund Office also maintains a complete list of all Employers who contribute to the Fund. The Fund Office will, on request, tell you and /or your Dependent spouse if an employer is contributing to the Fund.

Collective Bargaining Agreements

The Collective Bargaining Agreement, the Plan terms, and the eligibility rules summarized in this booklet determine your participation in the Plan. The Collective Bargaining Agreement is the contract between the Employers and the Automobile Mechanics Local No. 701 Union that requires Employers to contribute to the Plan on behalf of participants. For a copy of the Collective Bargaining Agreement, contact the Union Office at 1-708-482-1720.

Workers' Compensation and the Plan

The Plan does not replace and is not affected by any requirement for coverage under workers' compensation, any occupational disease act, or similar law. Benefits that would otherwise be payable under the provisions of such laws are not paid by the Plan.

If the Fund denies an eligible individual's claim for the reason that it is work-related, and the workers' compensation carrier also denies the claim, the Fund may agree to provide benefits under certain conditions. These conditions include the Trustees' determination, in their sole discretion, that a meritorious appeal of the workers' compensation claim exists, that a timely appeal of the workers' compensation claim exists, and that the eligible individual and the workers' compensation carrier are responsible for reimbursing the Fund out of any recovery obtained for the full amount of benefits that the Fund had provided in connection with a work-related claim. In addition, the participant must agree to reimburse the Fund out of any recovery and fully comply with the Fund's subrogation and reimbursement provisions.

Welfare Trust's Assets and Reserves

The Board of Trustees holds all assets in trust for the purposes of providing benefits to eligible participants and defraying reasonable administrative expenses.

Eligibility, Benefits and Discretionary Authority

The Plan's requirements for eligibility for benefits are shown in this booklet. Circumstances that may cause you to lose eligibility are also explained. You are not vested in the benefits described in this booklet. All Plan benefits are made available to you and your Dependent spouse by the Plan as a privilege and not as a right.

The Board of Trustees has sole authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Board. Benefits under this Plan will be paid only if and when the Board of Trustees, or persons to whom such decision-making authority has been delegated by the Board, in their sole discretion, decides the participant or beneficiary is entitled to benefits under the terms of the Plan. The decisions of the Board in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If the Plan makes inadvertent, mistaken, excessive, erroneous, or fraudulent payment of benefits, the Trustees or their representative will have the right to recover these types of payments. The Board of Trustees reserves the right to change, modify, or discontinue all or part of the benefits in this booklet at any time by action or amendment.

Rescission of Your Coverage

The Plan may rescind your coverage for fraud or intentional misrepresentation of a material fact. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan.

However, the Trustees may in their discretion, extend coverage beyond the date of loss of eligibility when there is a delay in administrative recordkeeping between your loss of eligibility and notice to the Plan of that loss, or when you fail to make timely required self-payments for coverage provided that contributions are made for that time. For any other unintentional mistakes or errors under which you were covered by the Plan when you should not have been covered, the Trustees may in their discretion cancel your coverage prospectively once the mistake is identified provided that contributions were made during that time.

Privacy Notice

The Plan is required to protect the confidentiality of your protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

Your rights under HIPAA include the right to:

- Receive confidential communications of your health information, as applicable;
- Copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Plan's Privacy Official at the Plan Office.

Breach Notification Rights under HIPAA

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Fund Office to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Fund Office is also required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Fund Office to provide notification to the media.

If your unsecured PHI is breached, the Fund Office will notify you without unreasonable delay and in no case no later than 60 calendar days after discover of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Plan up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Fund Office or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Fund Office has improperly followed the breach notification process.

Affordable Care Act

This Plan is maintained as a separate "retiree only" plan, and is therefore exempt from many of the requirements of the Affordable Care Act.

Your ERISA Rights

As a participant in the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each participant.

Continue Group Health Plan Coverage

You may also have the right to:

- Continue health care coverage for yourself or your spouse if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependent may have to pay for such coverage. Review this Plan/SPD and any documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including an employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Please note that you or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and review procedures.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the EBSA, Department of Labor:

Local Office

Employee Benefits Security Administration
Illinois Department of Labor
230 South Dearborn Street
Suite 2160
Chicago, Illinois 60604
1-312-793-2800 (General Information)

National Office

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210
1-866-444-3272

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by visiting EBSA's Web site at www.dol.gov/ebsa.

Definitions

Throughout this booklet, many words are used that have a specific meaning when applied to your Plan coverage. When you come across these terms while reading this booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. All definitions have been arranged in alphabetical order and are capitalized when used in the booklet.

COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985 which regulates the conditions and manner under which an employer can offer continuation of group health insurance to eligible persons whose coverage would otherwise terminate.
Collective Bargaining Agreement (CBA)	Any applicable collective bargaining agreement or existing in the future between an Employer and the Union providing for contributions to the Fund.
Covered Employment	Covered Employment is work performed by an employee for an Employer for which contributions are required pursuant to a CBA and/or participation agreement and are actually made to the Plan.
Custodial Care	Any services or supplies provided primarily for personal comfort or convenience that provide general maintenance, preventive, and/or protective care without any clinical likelihood of condition improvement. Custodial Care also means those services that do not require the technical skills, professional training, and/or clinical assessment ability of medical and/or nursing personnel to be safely and effectively performed.
Dependent	For purposes of the Plan a Dependent is the spouse of a Retiree who is not divorced or legally separated from the Retiree, and is of a marriage that was legally entered into in a jurisdiction that recognizes said marriage. A same-sex spouse legally married to a Retiree in a jurisdiction that recognizes same-sex marriage shall also be considered a Dependent under this Plan.
Employer	For the purposes of the Plan Employer includes: <ul style="list-style-type: none"> ➤ Any person, firm, association, partnership, or corporation that enters into a CBA with the Union requiring contributions to be made to the Fund on behalf of full-time employees; ➤ The Union, which is required to make contributions to the Fund for its full-time employees under the terms of a participation agreement; ➤ The Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund and Pension Fund with respect to its full-time employees; and ➤ Any employer that is required to make contributions to the Fund under the terms of a participation agreement for its full-time employees whose employment is not subject to a CBA.

Illness	A disease, disorder, or condition (including pregnancy, childbirth, and any related conditions) that requires treatment by a Physician.
Injury	Physical damage or hurt caused by a sudden unforeseen event resulting from an external source.
Medical Care	The ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an Illness or Injury.
Medically Necessary or Medical Necessity	<p>Services, treatments, or supplies ordered by your Physician that are:</p> <ul style="list-style-type: none"> ➤ Required to identify or treat an Injury or Illness; ➤ Appropriate and consistent with the symptoms, diagnosis, or treatment of the condition, disease, Illness, or Injury; ➤ In keeping with acceptable National Standards of Good Medical Practice; and ➤ The most appropriate that can be safely provided under the circumstances on a cost-effective basis.
Medicare	Medicare is a social insurance program administered by the United States government, providing health insurance coverage to people who are aged 65 and over; to those who are under 65 and are permanently physically disabled or who have a congenital physical disability; or to those who meet other special criteria.
Physician	A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (D.P.M.) and authorized to practice medicine, perform surgery, and to administer drugs under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.
Retiree	A former Employee who retires while covered under the Plan's Active Employee Benefits and is covered under the Retiree Benefits.
Retirement	Retirement means that the Employee ceases employment from an Employer and intends to abstain from actively working.
Union	Automobile Mechanics' Local No. 701, affiliated with the International Association of Machinists, AFL-CIO