AUTOMOBILE MECHANICS'
LOCAL NO. 701 UNION AND INDUSTRY
WELFARE FUND

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

OPTIONAL BENEFITS

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

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT – OPTIONAL BENEFITS

Dear Participant:

We are pleased to provide you with this new booklet which is intended to supplement the Welfare Plan Document and Summary Plan Description (Plan/SPD). This booklet describes certain optional welfare benefits "Optional Benefits" that you may enroll in through the Welfare Benefits Plan "the Plan" for the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund "the Fund" as of February 1, 2016 for participants covered under a Collective Bargaining Agreement that allows participation in the Plan.

The Plan allows you the opportunity to purchase and enroll in certain additional insurance benefits that could supplement the financial needs of you and possibly your Dependents. This booklet describes those benefits and how to enroll in them. The health benefits that are offered through the Plan are not described in this booklet. Those benefits are described in a separate Plan Document and SPD.

We have tried to describe all of the Optional Benefits as completely as possible in everyday language. We also organized this booklet to be useful to you. Please read this booklet carefully as it is important that you understand the benefits being offered.

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 supplemental booklet to the Plan 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	**Employer Trustees**
Armando Arreola	Ronald Fetty
Sam Cicinelli	Chris Konecki
Robert Keppler	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 insurers selected by the Board of Trustees, or other persons to whom such decision-making authority has been delegated, in their sole discretion, decide the Participant or beneficiary is entitled to benefits under the terms of an insurance contract offered by the Plan. The decisions of the insurers 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 insurers and their representatives 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.

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

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 as adding a Dependent through marriage, or if you and your spouse legally separate or become divorced.

This supplemental booklet to the Welfare Plan Documents describing Optional Benefits is a "Wrap Plan Document" and Summary Plan Description that provides the terms for the Optional Benefits that Participants may elect. This Wrap Plan Document incorporates all plan documents, summary plan descriptions, certificates of coverage, insurance contracts, and riders that apply to the underlying components of the Optional Benefits described in this booklet. This booklet, along with any certificates of coverage, insurance contracts and riders, may be modified by amendments or riders from time to time and such amendments or riders are hereby incorporated by reference. When accompanied by the summary plan description, certificate of coverage, insurance contract, rider, or other description of benefits for the appropriate component of the Optional Benefits, this document also operates as a summary plan description for that component of the plan. Other benefits offered through the Plan that are not fully insured Optional Benefits are described in a separate booklet and plan documents that are separate from this Wrap Plan Document.

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Eligibility

The following sections contain the eligibility rules for the Optional Benefits. Employees are eligible for benefits under the Plan as of the date the conditions in the following sections are met.

Initial Eligibility

You become eligible to elect an Optional Benefit under the Plan on the day you become an Employee of an Employer. You may also be eligible to participate if you are retired and the terms of the insurance contract for the component benefit permit you to enroll in an Optional Benefit.

Termination of Eligibility

You will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates or (b) the date on which you cease to be an Employee of an Employer. If permitted by the terms of the insurance contract, you may continue to participate in an Optional Benefit after your eligibility ceases.

Reinstatement of Eligibility

If you are a former Participant, you will become a Participant again if and when you become an Employee of an Employer.

Retiree Eligibility

If you are eligible for Retiree Benefits or the HRA for Medicare Eligible Retirees through the Automobile Mechanics' Local No. 701 Union and Industry Welfare Plan, you may be eligible to enroll in an Optional Benefit even though you are no longer an Employee as defined in this supplemental booklet only if the terms of the insurance contract governing an Optional Benefit permit you to enroll.

Optional Benefits

Coverage Options

You may choose under the Plan to purchase Optional Benefits. Optional Benefits are voluntary. It is your choice to purchase them or not. You must pay the entire cost of any Optional Benefits that you choose. You pay for Optional Benefits by completing enrollment information and paying the cost of premiums and any other fees directly to the insurer or its designated outside administrator. Notwithstanding anything herein to the contrary, Optional Benefits shall be limited to those benefits that are available to you under the insurance contracts identified in Schedule A. The Plan is not obligated to provide you with any benefits that are not paid for by the insurance contracts.

Description of Optional Benefits

While the election of one or more of the Optional Benefits may be made under the Plan, the Plan does not provide the benefits to you. The benefits you elect are provided by the insurance contracts identified in Schedule A.

Accordingly, the types and amounts of benefits available under each Optional Benefit described in Schedule A, the requirements for participating in such Optional Benefit, and the other terms and conditions of coverage and benefits under such Optional Benefit are controlled by the individual insurance contracts. The Plan is not obligated to provide you with anything that is not actually paid for or provided by the insurers. The Plan does not assume any obligation for the benefits provided by the insurance contracts which are entirely and exclusively the obligation of the insurers.

Elections

As a Participant, you may elect under the Plan, in accordance with the procedures described in this Section, to receive one or more Optional Benefits from the applicable insurance contracts identified in Schedule A.

Election Procedures

For certain Optional Benefits, prior to the commencement of each Plan Year, the Plan may hold an Election period during which you, as a Participant, will determine what type of group health plan coverage and Optional Benefits under the Plan you would like to participate in. This is called your "Election." Some of these coverages are offered on a guaranteed issue basis if you elect them during the Election period. This means that you can get coverage at the stated rates regardless of your health status or certain other factors established by the insurer. Some Optional benefits may have pre-existing condition limitations in the contracts of insurance that apply even if elected during the Election period.

Other Optional Benefits may permit you to enroll outside of the Election period. If you do not elect an Optional Benefit during the Election period and later want to add it, or you elected an Optional Benefit and want to increase the amount outside of the Election period, you may be subject to underwriting which means that you can be denied coverage or charged a higher premium based upon your individual circumstances as provided in the contracts of insurance. The Plan does not offer or guarantee coverage or rates other than as provided by the contracts of insurance. Should you elect to enroll in an Optional Benefit, you must complete an application for enrollment and work with the insurer or the insurer's third party administrator to pay for those benefits.

If you become an Employee after the Election period ends or after a Plan Year begins, you may be provided with an individual Election period. For benefits that are offered at guaranteed rates, you may need to make your election within specified time periods as set forth by the insurer. The insurer, or its third party administrator, will provide you with details on your individual Election period if you become an Employee outside of the Plan's regular Election period.

Failure to Make an Election

New Participants

If you are a new Participant and you fail to make an Election on or before the due date specified by the Plan in your Election materials for the Plan Year in which you become a Participant, such failure shall constitute an election by you to not enroll in an Optional Benefit. Depending on the underlying insurance contract for the Optional Benefit, you may not be able to enroll in that Optional Benefit until the next Election period. If you do not elect an Optional Benefit during your initial Election period and later want to add it, or you elected an Optional Benefit and want to increase the amount outside of the Election period, you may be subject to underwriting which means that you can be denied coverage or

charged a higher premium based upon your individual circumstances as provided in the contracts of insurance.

Continued Enrollment in Optional Benefits

Once you make an election to enroll in an Optional Benefit, you will remain enrolled in that benefit subject to the terms of the insurance policy that you have elected. For example, if you fail to timely send your premium payment to the insurance company or its designated administrator, you may lose your eligibility for that benefit. Also, subject to the terms of each underlying insurance policy, you may keep your Optional Benefit after you are no longer an Employee. Some benefits will terminate when you are no longer an Employee.

Election Changes by Administrator

If the Trustees determine, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination or other requirement imposed by the Code or any limitation on benefits provided to certain highly compensated employees or Key Employees for such year, the Trustees may take such action as they deem appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of Elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

Automatic Termination of Election

Any Election made under the Plan (including an Election made through inaction) shall automatically terminate on the date on which you cease to be a Participant in the Plan, although coverage or benefits under an insurance contract identified in Schedule A may continue (or may terminate) if and to the extent provided by such insurance contract.

Elections via Other Media

The Trustees may, in their discretion, use any electronic or other verifiable alternative media form that they deem necessary or appropriate for the Election of benefits under the Plan.

Filing and Appealing Claims

The types and amounts of benefits available under the Optional Benefits described in Schedule A, the requirements for participation, and the other terms and conditions of coverage and benefits under such Optional Benefits are controlled by the individual insurance contracts. The claims and appeals process for each Optional Benefit is described in the individual insurance contract. Optional Benefits are limited to the benefits actually paid by the insurance contracts. This Plan does not have any obligation or responsibility to pay any benefit not paid by the insurer. If you wish to receive a copy of the terms and limitations of any insurance contract, please contact Homeland HealthCare at 1-844-275-2719. The claims and appeals procedures described below only apply if the insurance contract for an Optional Benefit does not contain a claims and appeal process or relates to your eligibility for the Plan.

Filing Claims

To ensure prompt processing of your claims, please follow the claim submission guidelines indicated. All claims for eligibility to enroll in an Optional Benefit must be submitted to the Plan no later than one year from the date the triggering eligibility to enroll in an Optional Benefit occurred.

What is a Claim

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

- Eligibility. You may claim that you are eligible to enroll in Benefits under the Plan or to make or revoke an Election made under the Plan.
- Benefit Claims under an Optional Benefit Plan. You, your Dependents or your beneficiaries may have claims for benefits under your elected Optional Benefit plan. ***PLEASE NOTE: All claims for benefits under your Optional Benefits must be submitted to the insurer of the benefit. The Plan only provides the Election to apply and pay for coverage under an Optional Benefit plan. Therefore, the Plan is not responsible for and does not administer claims for any of the individual Optional Benefits.***
- Benefit Claims for group health benefits. Claims for benefits under the Premier Plus, Premier or Classic plans of benefits must be made in accordance with the claim and appeal procedures contained in the applicable combined plan document/SPDs which are described in a separate document.

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

How to File Claims for Benefits

- The insurance contracts offered under the Optional Benefits provide information regarding the filing of claims. Accordingly, to request a copy of the individual insurance contract's claims and appeals procedures, please contact Homeland HealthCare at 1-844-275-2719 and/or review the coverage

material in the individual insurance contract or you can contact the underlying insurer or its outside administrator for a copy of its claim and appeal procedures.

- To apply for a revocation of Election or to make an Election, please provide the applicable insurer or third party administrator with a copy of your written request. In most cases, such request **must** be received by the insurer or the third party administrator within certain timelines set forth in the insurance contract governing the optional benefit.

Claim Determinations

When you submit a claim for benefits, the appropriate claims administrator will determine if you are eligible for benefits and calculate the amount of benefits, if any. 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 to enroll in an Optional Benefit, 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 the insurer. 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;
  - A determination that a benefit is not a covered benefit;
  - Any other circumstances described in the insurance contract that cause your benefit to be denied; 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 should include:

- Sufficient information to identify the claim involved.
- The specific reason(s) for the determination as well as any standards used in denying the claim;
- Reference to the 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 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 applicable; 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 applicable, 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.

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 determination regarding your eligibility for benefits or the amount of the benefit, you may have the right to have the initial determination reviewed. You must follow the appeals procedure provided in the underlying contract, policy or plan document before you file a lawsuit under ERISA, the federal law governing employee benefits. Unless otherwise stated in an applicable insurance contract, appeals to the Plan must be filed within 180 days after you receive your notice of denial.

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 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 (if applicable) may be provided to you sooner. After a final determination of your claim on appeal is issued, 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 as dictated by the individual underlying plan document, insurance policy or insurance contract. If you are appealing the denial of a an issue related to your eligibility, 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 a determination is expected to be made.

Appeal Determination Notice

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

- Sufficient information to identify the claim involved;
- 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 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 if applicable under the insurance contract;
- 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.

Trustee Authority and Interpretation

All plan benefits are provided by contracts of insurance and all Trustee responsibility has been delegated to each insurer. The insurers will be the sole judges of the standard of proof required in any case and the application and interpretation of the insurance contract, and decisions of the insurers or their delegates are final and binding. Benefits under the Plan will be paid only when the insurers decide, in their discretion, that the eligible Participant or beneficiary is entitled to benefits in accordance with the terms of the insurance contract. In the event a claim for benefits has been denied, no lawsuit or other action against the Plan or its Trustees may be filed until the matter has been submitted for review under this ERISA-mandated review procedure. 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 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.

Plan Administration

Purpose of Plan

This Plan document is intended to evidence the establishment of certain Optional Benefits offered as part of the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund Plan. The Optional Benefits component of the Plan is effective February 1, 2016.

Plan Name

The name of the Plan is the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund Plan.

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
361 S. Frontage Road, Suite 100
Burr Ridge, Illinois 60527
Telephone: 1-708-482-0110 or toll-free at 1-800-704-6270

The present Trustees are listed here:

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 individual trustee, Welfare Fund employee, employer or Union or any representative of any employer or Union, is authorized to interpret the Plan. The Trustees' decisions will be awarded judicial deference. Benefits under this Plan will be paid only when the Board of Trustees (or persons or entities delegated by the Trustees) decides, in their discretion, that the eligible individual is entitled to benefits in accordance with the Plan's terms. If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, reference herein to the Plan Administrator shall be deemed to include reference to such delegate.

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 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. Termination may be made for any reason permissible under ERISA 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 complete the termination of the Optional Benefits described in this booklet. Trustees may apply 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 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
361 S. Frontage Road, Suite 100
Burr Ridge, Illinois 60527
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, 361 S. Frontage Road, Suite 100, Burr Ridge, Illinois 60527.

Source of Contributions

The benefits described in this booklet are provided through payment arrangements that you will individually make with the insurer of each benefit listed in Schedule A, or that insurer's designated administrator.

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

Welfare Trust's Assets and Reserves

The Optional Benefits described in this booklet are provided by contracts of insurance. Assets relating to other benefits provided through the Plan are maintained in a trust. Those benefits are described in separate Plan documents.

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 Dependents as a privilege and not as a right.

The Board of Trustees has sole discretion and 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 insurers selected by the Board of Trustees, or other 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 an insurance contract offered by the Plan. The decisions of the insurers 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 insurers and their representatives 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 participation for fraud or intentional misrepresentation of a material fact. A rescission 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, subject to the terms of the insurance contract for an Optional Benefit. 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. Notwithstanding any of the foregoing, the Trustees shall have no obligation to provide any benefits that are not approved and paid for by the insurers.

Cessation of Required Contributions

Nothing in the Plan shall prevent the cessation of coverage or benefits under any Optional Benefit identified in Schedule A, in accordance with the terms of such Optional Benefit, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits.

Examination of Records

The Administrator will make available to each Participant such of its records under the Plan as they pertain to the Participant, for examination at reasonable times during normal business hours. However, the Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

Reliance on Information

In administering the Plan, the Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the plans identified on Schedule A, or by accountants, counsel or other experts employed or engaged by the Administrator.

Information to be Furnished

Participants shall provide the Administrator or its designee with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time, for the purpose of administration of the Plan.

No Guaranty of Employment

The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Employer and any Employee. Nothing contained in the Plan shall give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Employee at any time, nor shall it give the Employer the right to require any Employee to remain in its employ or to interfere with the Employee's right to terminate his employment at any time.

Limitation on Liability

The Employer does not guarantee benefits payable under the Optional Benefits offered under the Plan and any benefits thereunder shall be the exclusive responsibility of the insurer or other entity that is required to provide such benefits under an insurance policy or contract. In no event is the Employer responsible for any contributions required of Employees to the Automobile Mechanic's Local No. 701 Union and Industry Welfare Fund, except to the extent that the Employer makes a deduction and is responsible for transmitting the deducted amounts to the Fund in a timely manner.

Non-Alienation

No benefit payable at any time under this Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind. This Plan does not give the Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund any right to any deductions hereby or to any assets of the Employer or any Employee.

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.

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 the 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

Wherever used, the singular includes the plural and the following terms have the following meanings, unless a different meaning is clearly required by the context:

Code	The Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.
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.
Dependent	For purposes of the Plan and unless provided otherwise by a contract of insurance a Dependent is: ➢ The legal spouse of an Employee who is not divorced or legally separated from the Employee; ➢ The child of an Employee who is under the age of 26; ➢ The unmarried child of an Employee age 26 or older who is disabled due to a mental or physical disability, provided the child: (1) became disabled due to mental or physical disability before age 26; (2) is incapable of self-sustaining employment and continues to be incapable of such employment; (3) is dependent on you for more than one-half of his or her financial support and maintenance; and (4) has his or her principle place of residence with you for more than one-half of the calendar year. Initially, you must provide written proof of your child's disability within 90 days after the date proof is requested. Thereafter, you need to provide proof of your child's continued disability as requested by the Fund Office but no more than annually. For the purposes of this definition of Dependent, the term "child" includes the following: natural child; legally adopted child, including a child placed with an Active Employee for adoption; foster child; stepchild who is the natural or adopted child of an Active Employee's spouse, or child identified as an alternate recipient under a Qualified Medical Child Support Order (QMSCO) entered by a court.
Election	An affirmative choice made by an Employee, in writing, to choose coverage under an Optional Benefit.
Employee	An individual who works under a Collective Bargaining Agreement for an Employer.

Employer	For the purposes of the Plan, Employer includes: ➢ Any person, firm, association, partnership, or corporation that adopts the Plan and 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 if it adopts the Plan; ➢ The Automobile Mechanics' Local No. 701 Union and Industry Welfare Fund and Pension Fund with respect to its full-time Employees, provided the Funds adopt the Plan; and ➢ Any employer that adopts the Plan 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.
Key Employee	Any person who is a key employee, as defined in section 416(i)(1) of the Code, with respect to an Employer.
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.
Optional Benefits	Coverages available to a Participant under the plans set forth in Schedule A.
Participant	Any individual who participates in the Plan and makes an election for coverage identified in Schedule A.
Significant Curtailment	An overall reduction in coverage provided under a plan so as to constitute reduced coverage generally.
Union	Automobile Mechanics' Local No. 701, affiliated with the International Association of Machinists, AFL-CIO.

Schedule A

Optional Benefits shall include the coverages available to a Participant under the following plans maintained by the Trustees:

- Group Long Term Disability Benefits (LTD)

  - Contract Administrator: Symetra
  - Type of Plan Administration: Third Party Administrator
  - Insurer: Symetra
  - Funding Arrangement: Benefits are provided through the purchase of insurance contracts with an insurer, which is solely responsible for the payment of benefits and determination of benefit claims.

- Group Short Term Disability Benefits

  - Contract Administrator: Symetra
  - Type of Plan Administration: Third Party Administrator
  - Insurer: Symetra

    Funding Arrangement: Benefits are provided through the purchase of insurance contracts with an insurer, which is solely responsible for the payment of benefits and determination of benefit claims.

- Group Supplemental Term Life Insurance

  - Contract Administrator: Symetra
  - Type of Plan Administration: Third Party Administrator
  - Insurer: Symetra
  - Funding Arrangement: Benefits are provided through the purchase of insurance contracts with an insurer, which is solely responsible for the payment of benefits and determination of benefit claims.

- Critical Illness Coverage

  - Contract Administrator: 5 Star
  - Type of Plan Administration: Third Party Administrator
  - Insurer: 5 Star

- Funding Arrangement: Benefits are provided through the purchase of insurance contracts with an insurer, which is solely responsible for the payment of benefits and determination of benefit claims.

➢ Aflac Accident Coverage

- Contract Administrator: Aflac
- Type of Plan Administration: Third Party Administrator
- Insurer: Aflac
- Funding Arrangement: Benefits are provided through the purchase of insurance contracts with an insurer, which is solely responsible for the payment of benefits and determination of benefit claims.

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