BAY AREA AUTOMOTIVE GROUP WELFARE FUND
4160 Dublin Blvd. Ste 400
Dublin, California 94568
Telephone 1-800-267-3232 - Fax 925-443-2035

July 11, 2018

PLAN CHANGE NOTICE
Summary of Material Modifications

Disability Benefit Claims Procedures, Anthem PPO Provider Agreements and Venue Selection

TO ALL ACTIVE PLAN PARTICIPANTS, DEPENDENTS and COBRA PARTICIPANTS:

PLAN TERMS vs. PPO NETWORK AGREEMENT OR MEDICARE (effective 4/1/17)

If you have a Self-Funded Medical option and are not enrolled in Kaiser, you are in the Self-Insured Plan and its "preferred provider organization" (PPO) with Anthem Blue Cross. Effective 4/1/17 if the PPO Network agreement or Medicare impose coverage terms that are different than the terms of the Plan described in your Summary Plan Description, the PPO agreement or Medicare rules will control how this Plan will cover, process, and pay the claim. This includes, but is not limited to, applicable time limits for processing claims and requirements regarding prior-authorization and utilization review.

DISABILITY CLAIMS PROCEDURES (effective 4/1/18)

A disability claim is any claim where to decide if you are eligible for the benefit the Plan must first determine whether you are "disabled." The Fund Administrator determines if you are eligible for disability benefits and the Fund's procedures are described in the attached procedures entitled "How to File a Claim for Disability Benefits."

VENUE REQUIREMENT (effective 4/1/18)

As noted in the Summary Plan Description, any lawsuit brought against the Bay Area Automotive Group Welfare Fund based on the denial of benefits or eligibility (or related matters) must be brought within one year of the date you are notified of the denial. **The only court in which such lawsuits may be filed is the United States District Court for the Northern District of California (which is located in San Francisco and Oakland)**.

If you have questions regarding this Notice please contact:

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In accordance with ERISA reporting requirements this document is intended to serve as a Summary of Material Modifications to the Plan.

PLEASE NOTE

This Notice is intended to amend your Summary Plan Description.

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to your plan of benefits. You should take the time to read this SMM carefully (and share it with your family) and keep it with your copy of the *Summary Plan Description*. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this summary and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases. The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify, terminate or interpret and decide all matters under the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason.

Si usted gustaría una copia en español, por favor de contactar la oficina de administracion de Bay Area Automotive Group Welfare Fund.

BAY AREA AUTOMOTIVE GROUP WELFARE FUND

MAY 2018

HOW TO FILE A CLAIM FOR DISABILITYBENEFITS

A claim for disability benefits is a request for disability plan benefits including extended coverage under the Plan for disabled participants ("disability benefits").

For disability benefit claim determinations and claim appeals, the people adjudicating disability claims and disability appeals (such as claim adjudicators and medical or vocational experts) will act independently and impartially.

Get a disability claim form from the Fund Administrator, complete the patient portion of the form, then give the form to your physician to complete the health care provider section. Return the completed disability claim form to the Fund Administrator (whose contact information is listed at the end of this document).

All disability claims must be submitted to the Plan within 90 days from the date of onset of the disability. Plan benefits will not be paid for any claim submitted after this period.

The Fund Administrator will determine your disability benefits claim no later than 45 calendar days after receipt. You will be notified if you did not follow the disability claim process or if you need to submit additional information or records to prove a disability claim and you have up to 45 calendar days to obtain this additional information. This 45-day period may be extended for up to 30 calendar days provided the Fund Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period that additional time is needed to process the claim, the special circumstances for this extension, and the date by which it expects to render its determination.

If, prior to the end of this first 30-day extension, the Fund Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the expiration of the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.

A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. If the Fund Administrator needs additional information from you to make its decision, you will have at least 45 calendar days to submit the additional information.

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

If the claim for disability benefits is approved, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.

If the claim for disability benefits is denied in whole or in part, a notice of this initial denial (an Adverse Benefit Determination) will be provided to you in writing. This notice of initial denial will:

(a) Give the specific reason(s) for the denial of disability benefits, including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views

presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable);

(b) Reference the specific Plan provision(s) on which the determination is based;

(c) Contain a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your claim;

(d) Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

(e) Provide an explanation of the Plan's appeal procedure along with time limits;

(f) Contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;

(g) Describe any applicable contractual limitation periods on benefit disputes (such as the Plan's one year time limit on when a lawsuit may be filed following an appeal denial);

(h) If the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request;

(i) If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(j) Include a statement that if a Participant is not proficient in English and has questions about a claim denial, they should contact the Fund Administrator to find out if assistance is available.

APPEAL OF A DENIAL OF A DISABILITY CLAIM

If you disagree with a denial of a disability claim, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period. You will be provided with:

(a) Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

(b) The opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) Automatically and free of charge, provided any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied disability claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;

(e) Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date;

(f) If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;

(g) A review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual; and

(h) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:

1) Consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

2) Provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

The Plan will make an appeal determination according to the following timeframes:

(a) **If an appeal is filed with the Plan more than 30 days before the next Board meeting**, the review will occur at the next Board meeting date.

(b) **If an appeal is filed with the Plan within 30 days of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.

(c) If special circumstances (such as the need to hold a hearing) require a further extension of time, the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(d) After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than five calendar days after the benefit determination is made.

The Plan may obtain a 45-day extension if you are notified of the need and reason for an extension before expiration of the initial 45-day period.

You will receive a notice of the appeal determination. If that determination is adverse, it will include:

(a) The specific reason(s) for the adverse appeal review decision of disability benefits, including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable);

(b) Reference the specific Plan provision(s) on which the determination is based;

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

(d) A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(e) A description of any applicable contractual limitation periods on benefit disputes (such as the Plan's one year time limit on when a lawsuit may be filed following an appeal denial);

(f) If the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request;

(g) If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

(h) A statement that if you are not proficient in English and have questions about disability benefits, filing a claim for disability benefits or about a claim denial, you should contact the Fund Administrator for assistance.

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