UAW RETIREE Medical Benefits Trust

2023 HEALTH CARE BENEFIT SUMMARY

THE FOLLOWING INFORMATION IS AN ADDENDUM TO THE SUMMARY PLAN DESCRIPTION (SPD) PUBLISHED IN 2020

Dear Trust Member,

The UAW Retiree Medical Benefits Trust (the "Trust") is committed to providing you access to quality, affordable health benefits. Annually, we focus on managing our health plan partners to provide you with the best-valued health care coverage in terms of quality, cost, and overall experience. Your health care benefits are there for you – so you can stay focused on moments that matter most to you.

The information in this document will assist you in making informed decisions about your health care plan, as well as serve you in the future.

We encourage you and your family to establish a relationship with a primary care physician (PCP) and visit them for wellness check-ups and an annual physical. During this time, discuss with your PCP age-related tests such as mammograms, colonoscopies, and cancer screenings. Also, be sure you are up-to-date on your immunizations.

Visit us online at uawtrust.org for additional helpful information and videos on your benefits. We continuously update our website to make it a valuable resource.

If you have questions about the information contained in this document, contact Retiree Health Care Connect (RHCC) at 866-637-7555.

We wish you the very best in health.

THE TRUST PROVIDES HEALTH CARE BENEFITS FOR CURRENT AND FUTURE ELIGIBLE UAW RETIREE MEMBERS OF CHRYSLER, GENERAL MOTORS, AND FORD. THE TRUST IS AN INDEPENDENT ENTITY AND NOT ADMINISTERED BY THE AUTOS OR THE UAW.

Medicare Cost Share
for All General Members[1]

	MA PPO Medicare Advantage PPO	TCN Traditional Care Network	HMO Health Maintenance Organization
Monthly Contribution	$0 Single $0 Family	$15 Single $30 Family	$0 Single $0 Family
Deductible (Amount you pay annually before the plan begins to pay a portion of the costs)	$150 / Person	$325 Single $600 Family	$400 Single $675 Family
Coinsurance (Amount you pay after your deductible is met)	10%	10%	N/A
Out-of-Pocket Max (Total amount you pay annually before the plan covers 100% of covered costs)	$500 / Person	$650 Single $1,325 Family	N/A
Primary Care Physician (PCP) Office Visit	$10 Copay / Visit	Covered by Medicare at 80%, after Part B deductible is met, you pay remaining 20%	$25 Copay / Visit
Specialist Office Visit	$20 Copay / Visit	Covered by Medicare at 80%, after Part B deductible is met, you pay remaining 20%	$35 Copay / Visit
Urgent Care (Includes Retail Health Clinics)	$25 Copay / Visit	$50 Copay / Visit	$25 Copay / Visit
Emergency Room (Waived if admitted)	$50 Copay / Visit	$125 Copay / Visit	$50 Copay / Visit

[1]Reflects in-network costs

Non-Medicare Cost Share
for All General Members[1]

	ECP Enhanced Care PPO	**HMO** Health Maintenance Organization
Monthly Contribution	$15 Single $30 Family	$15 Single $30 Family
Deductible (Amount you pay annually before the plan begins to pay a portion of the costs)	$325 Single $600 Family	$400 Single $675 Family
Coinsurance (Amount you pay after your deductible is met)	10%	N/A
Out-of-Pocket Max (Total amount you pay annually before the plan covers 100% of covered costs)	$650 Single $1,325 Family	N/A
Primary Care Physician (PCP) Office Visit	$10 Copay / Visit	$25 Copay / Visit
Specialist Office Visit	$20 Copay / Visit	$35 Copay / Visit
Urgent Care (Includes Retail Health Clinics)	$50 Copay / Visit	$50 Copay / Visit
Emergency Room (Waived if admitted)	$125 Copay / Visit	$125 Copay / Visit

[1]Reflects in-network costs

Cost Share for
GM and Chrysler Protected Members[1]

Protected status based on annual pension benefit income and/or retirement date.

	Medicare			Non-Medicare	
	MA PPO	**TCN**	**HMO**	**ECP**	**HMO**
Monthly Contribution	$0 Single $0 Family	$10 Single $10 Family	$0 Single $0 Family	$10 Single $10 Family	$10 Single $10 Family
Deductible (Amount you pay annually before the plan begins to pay a portion of the costs)	$0	$325 Single $600 Family	$0	$325 Single $600 Family	$0
Coinsurance (Amount you pay after your deductible is met)	N/A	10%	N/A	10%	N/A
Out-of-Pocket Max (Total amount you pay annually before the plan covers 100% of covered costs)	$0	$650 Single $1,325 Family	N/A	$650 Single $1,325 Family	N/A
Primary Care Physician (PCP) Office Visit	$0	Covered by Medicare at 80%, after Part B deductible is met, you pay remaining 20%	$25 Copay / Visit	$10 Copay / Visit	$25 Copay / Visit
Specialist Office Visit	$0	Covered by Medicare at 80%, after Part B deductible is met, you pay remaining 20%	$25 Copay / Visit	$20 Copay / Visit	$25 Copay / Visit
Urgent Care (Includes Retail Health Clinics)	$25 Copay / Visit	$50 Copay / Visit	$25 Copay / Visit	$50 Copay / Visit	$50 Copay / Visit
Emergency Room (Waived if admitted)	$50 Copay / Visit	$125 Copay / Visit	$50 Copay / Visit	$125 Copay / Visit	$100 Copay / Visit

[1]Reflects in-network costs

Cost Share for
Ford Protected Members[1]

Protected status based on annual pension benefit income and/or retirement date.

	Medicare			Non-Medicare	
	MA PPO	**TCN**	**HMO**	**ECP**	**HMO**
Monthly Contribution	$0	$0	$0	$0	$0
Deductible (Amount you pay annually before the plan begins to pay a portion of the costs)	$0	$0	$0	$0	$0
Coinsurance (Amount you pay after your deductible is met)	N/A	N/A	N/A	N/A	N/A
Out-of-Pocket Max (Total amount you pay annually before the plan covers 100% of covered costs)	$0	$0	N/A	$0	N/A
Primary Care Physician (PCP) Office Visit	$0	Covered by Medicare at 80%, after Part B deductible is met, you pay remaining 20%	$25 Copay / Visit	$10 Copay / Visit	$25 Copay / Visit
Specialist Office Visit	$0	Covered by Medicare at 80%, after Part B deductible is met, you pay remaining 20%	$25 Copay / Visit	$20 Copay / Visit	$25 Copay / Visit
Urgent Care (Includes Retail Health Clinics)	$25 Copay / Visit	$0	$0	$0	$0
Emergency Room (Waived if admitted)	$50 Copay / Visit	$0	$0	$0	$0

[1]Reflects in-network costs

Prescription Drug Coverage*

	Retail (One Month)	**Mail-Order** (90-Day)
Tier 1: Generic and Select Immunizations	$5	$5
Tier 2: Preferred Brand	$40	$40
Tier 3: Non-Preferred Brand	$115	$115

Specialty medications dispensed in one-month increments

*Members enrolled in Kaiser do not have pharmacy coverage through Optum Rx.
Copay amounts are different, see plan materials.
All other prescription drug coverage is provided by Optum Rx.

DENTAL COVERAGE

Dental coverage is provided through Delta Dental. The dental coverage offered by the Plan varies by provider's participation in the network. By going to a PPO dentist, you will have the lowest cost-sharing. Here is a summary of the benefit and applicable percentage of cost-sharing.

Routine, Diagnostic and Emergency Services

Service	PPO Dentist	Premier Dentist	Non-Participating Dentist
Exams, Cleanings (Routine or Periodontal Twice per year) **Fluoride Treatment**	100%	100%	100%
Emergency Treatment	100%	100%	100%
Brush Biopsy	100%	100%	100%

DENTAL COVERAGE

All Other Services

Service	PPO Dentist	Premier Dentist	Non-Participating Dentist
Minor Restorative Services (Fillings)	100%	90%	90%
Endodontic (Root Canals), **Periodontic** (Gum Disease), **Extractions** (Removal of Teeth), **Relines and Repair Services** (to Dentures, Bridges, and Implants)	100%	90%	90%
Major Restorative (Crowns) **or Other Oral Surgery**	90%	90%	90%
Prosthodontic Services (Bridges and Dentures)	70%	50%	50%
Orthodontic Services (Braces) **Treatment must begin prior to age 19**	60%	50%	50%
Orthodontic Lifetime Maximum	$2,000 per person		
Annual Plan Maximum	$1,700 per person		

- Preventive care services, including exams and cleanings, do not count toward the annual benefit maximum of $1,700 per person per calendar year.
- Out-of-network dentists are not under contract or required to accept Delta Dental's fee and may charge additional out-of-pocket costs for services, including services covered at 100%.

HEARING COVERAGE

Hearing coverage is provided through TruHearing. Services only available through audiologists in TruHearing's network. Here is a summary of the benefit and applicable cost-sharing.

Item/Service	Description/ Frequency	Your Cost Share*
Hearing Exam	Once every 36 months	$0
Hearing Aid Evaluation Test	Once every 36 months for each ear	$0
Conformity Evaluation	Once every 36 months for each ear	$0
Covered Hearing Aid (Including dispensing fee) **Eligible for one** (1) **hearing aid per ear every 36 months**	Mid-Level Mid-High Level Advance Level Flagship Level	$0 per hearing aid $250 per hearing aid $500 per hearing aid $650 per hearing aid
Initial Hearing Aid Fitting	Initial fitting and programming of purchased hearing aid	$0
Follow up visits	Provider visit after inital hearing aid fitting	First 12 months: $0 After 12 months: $20 per visit
Batteries	80 batteries included with purchase of each non-rechargeable hearing aid	$0
60-Day Hearing Aid Trial Period	Hearing aid may be returned or exchanged for 60 days following initial hearing aid fitting	$0 (additional charges may apply if hearing aid is exchanged for a more expensive hearing aid)
Warranty and Replacement Devices — Manufacturer Defect	Repair or replacement of hearing aid due to manufacturer defect (3 year warranty)	$0
Warranty and Replacement Devices — Loss and Damage	Repair or replacement of hearing aid due to loss or damage (3 year warranty); available once per hearing aid	$225 deductible per hearing aid

*****_Your cost share when using a provider in TruHearing's network. If you live more than 25 miles from the closest TruHearing provider, contact TruHearing for direction on how to see a provider outside of TruHearing's network. Additionally, you may have access to mobile providers in TruHearing's network._

HEARING COVERAGE

Item/Service	Description/ Frequency	Your Cost Share*
Initial Ear Molds (children up to age 7)	Covered with purchase of hearing aid styles that require ear molds	$0
Initial Ear Molds (enrollees over age 7)	Covered with purchase of hearing aid styles that require ear molds	$0
Replacement Ear Molds (children up to age 7)	Children up to age 3: up to four (4) replacement ear molds each year Children ages 3-7: up to two (2) replacement ear molds each year	$0 (cost of additional ear molds is your responsibility)
Replacement Ear Molds (enrollees over age 7)	Not Covered	Full cost of additional ear molds

*****_Your cost share when using a provider in TruHearing's network. If you live more than 25 miles from the closest TruHearing provider, contact TruHearing for direction on how to see a provider outside of TruHearing's network. Additionally, you may have access to mobile providers in TruHearing's network._

- Approved provider type: Hearing instrument specialist covered under certain situations.

VISION COVERAGE

Vision coverage is provided through Davis Vision. Here is a summary of the benefit and applicable cost-sharing for in-network providers.

Service	In-Network Coverage
Routine Vision Exam	Covered in Full Every 12 Months
Re-examination by Ophthamologist (within 60 days of initial Optometrist examination, when medically necessary and with a referral)	$45 Allowance Towards Total Cost
Standard Lenses (Glass or Plastic) • **Single Vision** • **Lined Bifocal/Trifocal** • **Standard Progressive Addition Lenses[2]** • **Special** (Lenticular, Aspheric, etc.)	Covered in Full Every 12 Months
Davis Vision Collection Frames	Covered in Full Every 12 Months
Frames from Provider Selection	$40 Allowance Every 12 Months
Contact Lens Evaluations, Fitting and Follow Up Care (Instead of Glasses)	$40 Allowance Every 12 Months
Contact Lenses (Instead of Glasses)	$75 Allowance Every 12 Months
Medically Necessary Contact Lenses	$350 Allowance Every 12 Months

Davis Vision Enhancements:

1. Two-year eyeglass breakage warranty.
2. 100% coverage on certain standard progressive lenses. Members should check with their eye care provider for which brands and lens types are covered.
3. Costco is in-network. Members can obtain services at Costco (must be a Costco member).

Dental, hearing and vision plans do not cover all expenses and include limitations and exclusions. Please refer to your carrier's plan documentation to determine which services are covered and to what extent.

Plan Changes & Other Info

Benefit Enhancements

Partial Hospitalization for Behavioral Health

Trust health plans cover mental health or substance abuse services for up to 35 visits, lasting up to eight (8) hours, in a Partial Hospitalization Treatment Facility. Partial hospitalization for mental health or substance abuse no longer counts against the maximum number of inpatient hospital coverage or outpatient mental health visits.

Telehealth Coverage

All Trust health plans cover telehealth for office visits, behavioral health, and other types of specialty services. This coverage option is a way to make health care more convenient and accessible, allowing you to consult a doctor via videoconference or telephonically. Some services may not be considered appropriate for telehealth long-term. Call the number on the back of your medical ID card for information on telehealth visit costs and to find out how to set up telehealth services through your health plan.

Changes to TCN and ECP Plans

Medical emergency definition

A change in the definition of a medical emergency and removal of the qualifying requirement that the onset of a condition must have occurred within 72 hours to be covered under an emergency room visit.

> The updated description of a medical emergency is a serious or permanent health-threatening or disabling condition, including certain accidental injuries, that requires immediate medical attention and treatment. The condition must be such a nature that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect failure to render treatment immediately could result in significant impairment of bodily functions, cause permanent damage to the individual's health, or place the individual's life in jeopardy. Signs and symptoms verified by the treating physician at the time of treatment, and not the final diagnosis, must confirm the existence of a threat to life of bodily functions.

Behavioral health outpatient services limit and provider type

Elimination of the limit of 35 visits on outpatient mental health and substance abuse visits. Additionally, the benefit includes physician assistants as a covered provider.

Tobacco cessation program requirement

Removal of the requirement that members must participate in a carrier-approved tobacco cessation program to receive coverage for tobacco cessation prescription drugs.

Over-the-Counter (OTC) Program

The Trust added an over-the-counter (OTC) benefit giving eligible members an annual allowance to order approved non-prescription medications and health-related items—such as bandages, aspirin, cold and sinus medicine, and vitamins and minerals—up to twice per calendar year. The dollar value of the allowance depends on your health plan.

Health Care Plan	Annual Allowance
Medicare Advantage (MA) PPO **Medicare Advantage (MA) HMO** **Enhanced Care PPO (ECP)**	$150
Traditional Care Network (TCN)	$50
Non-Medicare HMO	Not eligible

Eligible members are automatically enrolled; no action is required.
More info: uawtrust.org/otcbenefit

All OTC benefit information will have the UAW Trust OTC logo:

Expanded Health Benefits

Several Trust health plans have enhanced benefits.

All enhancements listed are for in-network providers only.

- **Enhanced Care PPO (ECP)***
  - **Allergy testing:** Covered, subject to deductible and coinsurance**
  - **Ear wax removal:** Covered, subject to deductible and coinsurance**
  - **Chiropractic care:** $20 copay per visit, service must be completed by licensed provider †
  - **Cardiac, respiratory and pulmonary in-network rehabilitation:** Services covered at 100%
  - **Outpatient behavioral health:** Visits covered at 100%
  - **Inpatient hospital admission:** Unlimited days (when it is determined to be medically necessary because the medical criteria and guidelines are met)

- **Traditional Care Network (TCN)***
  - **Acupuncture (for lower back pain only):** Covered, subject to deductible and coinsurance
  - **Allergy testing:** Covered, subject to deductible and coinsurance**
  - **Ear wax removal:** Covered, subject to deductible and coinsurance**
  - **Chiropractic care:** $20 copay per visit, service must be completed by licensed provider †
  - **Cardiac, respiratory and pulmonary in-network rehabilitation:** Services covered at 100%
  - **Outpatient behavioral health:** Visits covered at 100%
  - **Inpatient hospital admission:** Unlimited days (when it is determined to be medically necessary because the medical criteria and guidelines are met)

- **Medicare Advantage PPO**
  - **Outpatient visits for mental health and substance use disorders:** Covered 100%, no limit on number of visits
  - **Skilled nursing facility:** Covered 100% for days 1-50, $20 copay per day for days 51-100
  - **Diabetic eye exams:** Covered 100%
  - **Diabetic shoes:** Coverage for two (2) pairs per year±

* All benefits listed covered 100% for Ford Protected members

** May be subject to office visit copay

† Limited to 24 visits per year

± Also applies to Protected members

Skilled Nursing Facility Care Expanded for All Medical Plans

Beginning January 1, 2023, the Skilled Nursing Facility (SNF) benefit will be expanded for in-network care under all Trust-sponsored medical plans. A SNF is a facility outside of the hospital that provides nursing care 24 hours a day under the supervision of a physician and/or registered nurse.

There will no longer be a limitation on the allowed amount of days of care provided per benefit period. Additionally, there will no longer be a non-confinement period required to reset the benefit (when it is determined to be medically necessary because the medical criteria and guidelines are met).

Ford Members Only

Medicare Part B Premium Subsidy

For Ford Retirees retiring after October 1, 1979, a Medicare Part B Premium Subsidy is provided to help Retirees, Surviving Spouses, and Surviving Same Sex Domestic Partners pay for Medicare Part B. Those enrollees receiving a Retirement Plan due to a deferred vested benefit or a pre-retirement survivor benefit are not eligible. The enrollee must be receiving a pension from the pension plan in order to be eligible; those receiving survivor's insurance are not eligible. A Ford Retiree cannot also receive this benefit as a Surviving Spouse or Surviving Same-Sex Domestic Partner. The Medicare Part B Premium Benefit is $76.20 per month.

Enrollees eligible for Medicare Part B must enroll and remain enrolled in Part B to be eligible to receive this benefit. Retirees under age 65 who are disabled or have End Stage Renal Disease are also eligible for this benefit, provided they have enrolled in Part B. If eligible, the Medicare Part B Premium Benefit will be included in the enrollee's pension check.