

# Summary Plan Description 2020



# WELCOME AND INTRODUCTION

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Dear UAW Retiree Medical Benefits Trust Member:

We are pleased to provide you with this Summary Plan Description (SPD) booklet, which explains the health care benefits available to eligible UAW Retiree Medical Benefits Trust members and their dependents. The benefits described in this SPD were in effect as of January 1, 2020, and as modified after that date.

The UAW Retiree Medical Benefits Trust, or the “Trust,” was established in January 2010 as a result of the Settlement Agreements between the UAW and the three Auto Companies. There are three separate employee welfare benefit plans, known as the UAW Chrysler Retirees Medical Benefits Plan, the UAW Ford Retirees Medical Benefits Plan, and the UAW GM Retirees Medical Benefits Plan, which are collectively referred to as the “Plan” in this SPD.

The Committee of the Trust acts on behalf of the UAW Retirees enrolled in the Trust. The Committee has established a retiree health program. This SPD describes the health care coverage you have under the Trust. Unique terms for your particular Plan will be included in the Plan Document, the Benefit Highlights Letters, and the Health Care Benefit Summaries for that Plan.

This SPD is intended to be just that – a summary – in everyday terms, of the main features of your benefit program. It contains general information only. The Schedule of Benefits for your Plan is part of the SPD. The Committee may change the benefits described in this SPD from time-to-time. If the Committee changes the benefits, you will receive a Benefit Highlights Letter that will describe the changed benefits and other information in greater detail. You should carefully read the Benefit Highlights Letters when they arrive. Please inform Retiree Health Care Connect of a change in your address or any dependent information so that you receive all updates.

Please keep this SPD, the Schedule of Benefits, Benefit Highlights Letters, and any other materials the Trust sends you related to your coverage, so that you always have up-to-date information concerning your benefits readily available. We urge you to read this information and share it with your family members, caregiver, and others as needed. If you are enrolled in an HMO or Medicare Advantage plan, the Carrier for the Plan will provide you with a booklet, such as an Evidence of Coverage or Certificate of Coverage that describes the detailed terms of your coverage and the rules that govern your particular Plan. If you have questions about any of this information, contact Retiree Health Care Connect at 866-637-7555 or the Carrier for your Plan.

Sincerely,

The Committee of the UAW Retiree Medical Benefits Trust

# How to use this booklet/SPD

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This SPD has been designed to be as readable as possible. At times, the language will be technical or legalistic, but language is there because of certain requirements.

As you read through this SPD, you will notice that certain sections are designed in different colors.



is for those members eligible for Medicare, regardless of whether or not they are enrolled in Medicare.



is for those members that do not have Medicare.



is for all members.

Some pages contain information in boxes called “Call Out” boxes. These Call Out boxes stress important points from that section. You should give these boxes extra attention when you are reading this SPD.

# Retiree Health Care Connect

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## 866-637-7555

Enrollees can get answers to their questions by calling Retiree Health Care Connect (sometimes shortened to “RHCC”). Retiree Health Care Connect represents the Plan and can either answer your questions or redirect you to where you can get an answer.

Retiree Health Care Connect can help you with the following subjects:

- Enrollment and Disenrollment (ex: How do I enroll my child?)
- Eligibility (ex: Is my child eligible after age 18? What happens in a divorce?)
- What alternative health plan options do I have in my area?
- COBRA coverage when Plan coverage stops

Please report any deaths or other life-changing events to Retiree Health Care Connect. RHCC can advise you as to how, if at all, that event changes your eligibility. See the chapter on Eligibility for more specific information.

# INFORMATION AND COMMUNICATION

The Trust communicates to you throughout the year for a number of important reasons. Some of the communications are required by law, while others seek to advise you on your health and benefits. Many of the communications that go out to all eligible enrollees are posted on the Trust’s website at <http://www.uawtrust.org>. Also on the website, you will have the ability to access RHCC’s and the Carriers’ websites, download additional copies of some communications, and find out more information about the Trust generally, including some videos on the history of the Trust.

Below is a chart that describes the communications you will receive from the Trust periodically. Your first one will be the Welcome Kit, which you may have just opened to find this SPD.

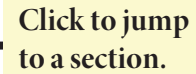
Name of Communication	Usual Time Received	What It Is	What You Should Do with It
<b>Welcome Kit</b>	Within 90 days of retirement or enrollment in the Plan	Packet of information about your Trust benefits, including this SPD, the Health Care Benefit Summary and Quick Reference Guide	Open it and read the material inside, then put the documents in a safe place
<b>Notice of Minimum Essential Coverage (for non-Medicare members)</b>	January-February	IRS-required notification that your Trust medical coverage meets minimum requirements	Have it in-hand when you are filling out your federal income taxes
<b>Benefit Highlights Letter</b>	August-September	Statement of updates to the plans and applicable cost-sharing for the upcoming year	Read it carefully and store with your SPD
<b>Status of Trust Letter</b>	November-January	Description accompanying the Summary Annual Report that describes the progress and status of the Trust	Read it
<b>Summary Annual Report</b>	November-January	Department of Labor required summary of the Trust’s financial status	Read it



Name of Communication	Usual Time Received	What It Is	What You Should Do with It
<b>Notice of Privacy Practices</b>	At retirement and following a change in regulation afterward	Department of Health and Human Services required statement of Trust's obligations as to your personal health information under HIPAA	Read it carefully and store with your SPD
<b>Annual Notice of Change/Evidence of Coverage (for Medicare members)</b>	September-December	Statement of updates to your Medicare Advantage and Part D plans, including new cost-sharing or new service limits	Read it carefully and store with your SPD
<b>Notice of New Plan</b>	July-December (when a new plan is becoming available)	Notification to you that you may be eligible for a new plan starting in the next year	Read it carefully and consider which plan is best for you
<b>Age-in to Medicare Letter (for members turning 65 years old)</b>	3 letters possible – 1st: 90 days before your 65th birthday 2nd: Month of your birthday, if not enrolled 3rd: Month after your birthday, if you have not yet enrolled	Notification that you will soon be eligible for Medicare and should enroll	Read it, follow its instructions, and enroll in Medicare Parts A and B
<b>General Enrollment Letters (members with Medicare Part A only)</b>	December-February	Notification that you need to enroll in Medicare Part B	Read it and enroll in Medicare Part B
<b>Age 19-26 Dependent Audit (members with Dependent Children aged 19-26)</b>	August-September	Verification of dependent eligibility under Plan rules	Read it and respond
<b>Health Notice Discussing a Particular Benefit or Condition</b>	Various times	Notification of certain Plan benefits you are encouraged to take advantage of or a discussion of an important medical condition you have and how the Plan can help you manage it	Read it and consider its suggested services

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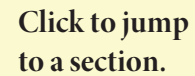
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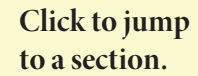


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# I. ELIGIBILITY AND ENROLLMENT

## A. RETIREE ELIGIBILITY

To be eligible for retiree health coverage under the Plan, an individual (a “Retiree”) must be eligible for such coverage based on the terms of retirement from his or her Auto Company, must be included within the specific classes involved in the three Settlement Agreements between classes of present and future retirees and the Auto Companies, and must make any required payments for coverage (“Contributions”). The Settlement Agreements and the agreement creating the Trust can be found on the Trust’s website at <http://www.uawtrust.org>.

You are not eligible for coverage under the Plan if you:

- Are eligible only for a deferred vested pension benefit under your Auto Company’s pension plan;
- Are not a Retiree; or
- Were discharged for cause, even if you are receiving a pension from your Auto Company’s pension plan.

**The term “Primary Enrollee” refers to the person eligible for coverage under the Plan. The Primary Enrollee may be a Retiree, a Surviving Spouse, or a Surviving Same-Sex Domestic Partner.**

Retirees and Surviving Spouses (or Surviving Same-Sex Domestic Partners) are included in two categories, “Protected” and “General,” that relate to certain differences in cost-sharing and contributions. Primary Enrollees are considered “General” Enrollees when they do not meet any of the following tests to be considered “Protected:”

- In the case of a Retiree, those who retired prior to October 1, 1990
- In the case of a Surviving Spouse, those whose Retiree spouse retired prior to October 1, 1999
- For Enrollees who were enrolled in the Plan prior to January 1, 2020, those who receive both an annual pension benefit income of \$8,000 or less and a monthly pension benefit rate of \$33.33 or less per month per year of credited service.

## B. DEPENDENT ELIGIBILITY

### 1. Eligibility for Your Spouse

You can have your Spouse covered if you are covered under the Plan as a Retiree. You may get married and add your new Spouse to your coverage if you are an enrolled Retiree. A spouse is defined as an individual who is married to a Retiree with a valid marriage certificate from a state, the District of Columbia, a U.S. territory, or a foreign country (“Jurisdiction”) where such marriage has been recognized as legal according to the laws of that Jurisdiction, regardless of whether the spouse or Retiree is a current resident of that Jurisdiction.

Your common-law spouse is eligible for coverage if the relationship is recognized by the laws of the state in which you are a resident, and you meet the requirements as required by the Plan.

2. Eligibility for Your Unmarried Same-Sex Domestic Partner and Dependents of Your Same-Sex Domestic Partner

Your unmarried Same-Sex Domestic Partner and your Same-Sex Domestic Partner's Dependent Children who were covered by your active auto plan at the time of your retirement are eligible for coverage under the Plan, provided you are an eligible Retiree and you meet the documentation requirements as required by the Plan. You may not add a new Same-Sex Domestic Partner or child of your Same-Sex Domestic Partner after you retire.

The Dependent Children of your Same-Sex Domestic Partner must meet the tests of eligibility for Dependent Children as noted in the section on Dependent Children.

3. Eligibility for Surviving Spouses and Surviving Same-Sex Domestic Partners with or without Dependents

If you die while you are an eligible Retiree, your Surviving Spouse, Same-Sex Domestic Partner, and Dependent Children may be eligible for coverage.

To be a Surviving Spouse, Surviving Same-Sex Domestic Partner, or surviving Dependent Child you must:

- Either be (1) eligible to be enrolled on the date of the Retiree's death or (2) eligible to be enrolled in the active Auto Company plan and the Retiree was eligible to retire on the date of death;
- If eligible, be enrolled in Medicare Parts A and B; and
- Pay the required Contribution or have the Contribution taken by direct debit

**See Introduction to Medicare for more information. Surviving Spouses and Surviving Same-Sex Domestic Partners must be enrolled in Medicare Parts A and B, if eligible, to stay enrolled in the Plan.**

Surviving Spouses and Surviving Same-Sex Domestic Partners may not add new Dependents. A Surviving Spouse/Same-Sex Domestic Partner may continue coverage for a Dependent Child who was enrolled by a Retiree prior to his/her death and who continues to meet the eligibility tests.

If you do not enroll in both Medicare Parts A and B when you are eligible, you will lose your coverage. Coverage for Survivors without Medicare Parts A and B can be reinstated as of the Medicare Parts A and B effective date. A Surviving Spouse will be required to provide a copy of the death certificate of the Retiree that states that the Retiree was married at the time of death. A Surviving Spouse/Same-Sex Domestic Partner who is eligible for coverage under the Plan but whose pension benefits are not sufficient to pay the full amount of Contributions or who is not eligible for pension benefits from an Auto Company, must pay the Contributions when billed or direct debited by Retiree Health Care Connect on a monthly basis.

#### 4. Eligibility for Dependent Children

Children are eligible for coverage under the Plan if they meet all of the following five eligibility tests. Retirees may add children as dependents, but Surviving Spouses/Same-Sex Domestic Partners may not.

##### The Five Eligibility Tests

Your children and the children of your Spouse or Same-Sex Domestic Partner must meet ALL of the following FIVE eligibility tests:

(1) **Relationship** – “children” include:

- Your natural or legally adopted child;
- Your stepchild (child of the Retiree’s current Spouse or Same-Sex Domestic Partner);
- A child placed with you for legal adoption who is under age 18; or

**Children may be eligible for health care coverage up to the end of the month in which they turn 26 as long as they continue to meet the eligibility criteria. Documentation will be required to be submitted to Retiree Health Care Connect (RHCC) during periodic audits.**

- A child by legal guardianship. Legal guardianship orders must state that custody is granted to the Primary Enrollee. Children placed in the custody of a Primary Enrollee may be eligible for coverage until the end of the month in which they turn age 18, except children under Legal Guardianship or Custody Order on or before December 31, 2010, are eligible until the end of the month in which they turn age 26. Children under Legal Guardianship are not eligible to continue as permanently and totally disabled dependents beyond the ages specified in this paragraph.

(2) **Age** – “children”:

- May be eligible until the end of the calendar month in which they reach age 26.
- Are not subject to the age restriction if they were determined to be permanently and totally disabled prior to the end of the calendar month in which they reached age 26. The child would need to be enrolled in coverage immediately prior to determination of permanent and total disability status.
  - A dependent is determined to be permanently and totally disabled if the dependent has a medically determinable physical or mental condition that prevents the dependent from engaging in substantial gainful activity and which can be expected to result in premature death or is of long-continued or indefinite duration.
  - To be eligible, a permanently and totally disabled dependent must not earn more than \$10,000 per year from employment.

- (3) **Marital Status** – “children” must not be married.
- (4) **Residency** – “children” must:
- Live with the Primary Enrollee as a member of the household;
  - Live away from the Primary Enrollee as a result of attending an institution of higher learning as a student;
  - Live in a group home or other health care facility;
  - Live apart from the Primary Enrollee (or the Primary Enrollee’s Spouse, if living) when that Primary Enrollee (or Spouse) lives in a group home or other health care facility; or
  - The Primary Enrollee must have legal responsibility for providing health care coverage for the child, and the child must reside with the custodial parent. See “Dependency” below.
- (5) **Dependency** – “children” must:
- Be dependent on the Primary Enrollee, that is, be someone for whom the Primary Enrollee could claim as a dependent on his or her federal income tax return.
  - Be the Primary Enrollee’s legal responsibility for providing health coverage through a divorce decree, court order related to divorce, a Qualified Medical Child Support Order (QMCSO), or a National Medical Support Order. A QMCSO or a National Medical Support Order may require you to enroll your child in the Plan. The child’s eligibility under this provision will not extend beyond the Plan’s age limits for Dependent Children. The child must continue to meet the Plan’s eligibility requirements except those waived by a court order or QMCSO (residency and dependency). Procedures for handling QMCSOs are available, upon request, at no cost.

##### 5. Medicare Status

All Dependents must enroll in Medicare Part A when first eligible, unless first eligible before January 1, 2017. If residing in the U.S., a Medicare eligible Dependent must be present lawfully.



## C. ENROLLMENT

### 1. Deferring Enrollment

You may defer enrollment under the Plan. This might occur, for example, if you have coverage under another plan. If you decide to enroll in the Plan, coverage will begin on the first day of the month following notification to Retiree Health Care Connect (RHCC), along with submission of any required documentation. Failure to enroll a Dependent, whether Spouse or Child, when first able will be treated as deferring enrollment, meaning Dependent will be enrolled the first day of the month following notification. In any case of deferment, if (RHCC) is notified without any delay (the birth of a child or a marriage), then coverage can be effective immediately upon notice.

**Call RHCC at 866-637-7555**

### 2. Enrolling a New Dependent

You should contact Retiree Health Care Connect to add your new Dependent within 30 days from the date of the event (marriage, birth, adoption, placement for adoption, etc.). If reported within 30 days of the event, coverage will begin on the date of the event. If reported after 30 days of the date of the event, coverage will begin on the first day of the month following notification to Retiree Health Care Connect and all required proof is submitted (see sub-section D later). Surviving Spouses/Surviving Same Sex Domestic Partners may not add a new Dependent.

### 3. Enrolling as a Surviving Spouse or Surviving Same-Sex Domestic Partner

If you are the Spouse or Same-Sex Domestic Partner of a Retiree (and not a Retiree yourself), when the Retiree dies, you should contact Retiree Health Care Connect. They will take your information and help you understand when your coverage as a Survivor will begin.

### 4. Removing Dependents from Coverage

You must notify Retiree Health Care Connect to remove a Spouse, Same-Sex Domestic Partner, or Dependent Child from coverage as soon as the individual no longer meets the eligibility requirements. **You will be liable for any claims paid on behalf of any individual who was not eligible for benefits.** The Plan will not be responsible for these claims.

### 5. Reinstatement

#### a. Reinstating a Dependent

If a Dependent Child loses eligibility and later becomes eligible again (for example, changing residency and then returning to the Retiree's home at a later date), coverage may be reinstated, as long as the other eligibility tests are met. Coverage will begin on the first day of the month following the Primary Enrollee's notification to Retiree Health Care Connect regardless of date of termination.

b. Reinstatement after Termination for Non-Payment

If you fail to make the required Contributions, your coverage under the Plan will be terminated at the end of the month for which the last payment was made. Coverage may be reinstated retroactively upon receipt of all past due monthly contributions. At the time of reinstatement, the Primary Enrollee must elect pension deductions (if receiving a pension) or direct debit from a bank account for future Contributions. If you do not make up the past-due monthly contributions, you can be reinstated the first day of the following month, but you will have no coverage for any services received during that lapse. There are certain Medicare restrictions regarding retroactive reinstatement into Medicare Advantage and Medicare Part D plans that may result in assignment to another plan.

c. Reinstatement after Termination for Failure to Enroll in Medicare Part A

If you, the Primary Enrollee, fail to enroll in Medicare Part A when you first become eligible (for most Enrollees this is when you turn 65), the Plan will terminate your coverage and the coverage for any of your Dependents. There may be certain exceptions to this rule. If you then enroll in Medicare Part A, your coverage can be reinstated once the Plan receives confirmation from Medicare of your enrollment.

d. Reinstatement after Termination for Unlawful Presence

If your coverage is terminated by the Plan because you become eligible for Medicare and reside in the U.S. illegally (for example, you were not a U.S. citizen or were not on a valid visa), you can be reinstated after you provide proof of your legal residency in the U.S. Such reinstatement will be the first day of the following month. A similar reinstatement is available for a termination for your Dependents.

e. Reinstatement after Elective Termination

You can decide at any time to disenroll from coverage under the Plan. If you do so and then later decide that you would like to be covered by the Plan again, you must contact and have your coverage reinstated. That coverage will be effective the first day of the following month. However, if you can show proof of continuous coverage by another health plan while you were not covered by the Plan, your coverage can be effective immediately (subject to certain Plan restrictions). There are certain Medicare timing requirements regarding enrollment into Medicare Advantage and Medicare Part D plans, so you may be placed in a different plan option temporarily.

f. Unforeseen Circumstances

You may have your coverage terminated by the Plan because you failed to provide required documentation by a certain date. However, if you were unable to provide the requested information because of circumstances outside of your control or that you could not have predicted, then you can have coverage reinstated back to when it was first removed. In order to have coverage back to that date, you must still provide the required information, as well as pay any Contributions and cost-sharing you may owe.

## D. SUBMISSION OF PROOF

The Plan will require that you send proof of eligibility whenever you add a new Dependent or at other times as the Plan may determine, such as with initial eligibility as a Surviving Spouse. In such event, you must submit the requested proof, which could include copies of marriage certificates, driver's licenses, the front page of federal income tax returns, court orders (all pages), signed affidavits, or other specified documents. Failure to provide all required documentation, including proof of dependent status and Social Security number, may result in the denial or cancellation of dependent coverage.

## E. Coverage Starts and Stop Dates

This chart shows coverage beginning and ending dates based on certain life events.

	Coverage Begins	Coverage Stops*†
<b>Retiree</b>	On your retirement date	<ul style="list-style-type: none"> <li>• The end of the month of Retiree's death if dependents are enrolled</li> <li>• The end of the month for which the last payment was made</li> <li>• The end of the second month after the month where Retiree does not enroll in Medicare Part A when eligible</li> <li>• The end of the month where Retiree is present unlawfully in the U.S. while eligible for Medicare</li> </ul>
<b>Spouse</b>	<ul style="list-style-type: none"> <li>• On the date the Retiree's coverage begins;</li> <li>• The date that the Retiree marries the Spouse, if reported within 30 days of marriage; or</li> <li>• If more than 30 days after the event, the first day of the month following the date of notice.</li> </ul>	<ul style="list-style-type: none"> <li>• The date of a final decree of divorce from the Retiree</li> <li>• The end of the month for which the last payment was made</li> <li>• The end of the second month after the month where Retiree or Spouse does not enroll in Medicare Part A when eligible</li> <li>• The end of the month where Retiree or Spouse is present unlawfully in the U.S. while eligible for Medicare</li> <li>• Spouse's death</li> </ul>

\* Individuals whose coverage stops may be eligible for COBRA. (See COBRA Continuation Coverage Section IX sub-section A)

† All coverage will end on the date the Plan or Trust is terminated.

	Coverage Begins	Coverage Stops*†
<b>Same-Sex Domestic Partners and their Children</b>	On the date the Retiree’s coverage begins, if the Same-Sex Domestic Partner was covered under the active plan before retirement.	<ul style="list-style-type: none"> <li>• The date on which the Same-Sex Domestic Partner relationship or eligibility ends</li> <li>• The end of the month for which the last payment was made</li> <li>• The end of the second month after the month where Retiree or Same-Sex Domestic Partner does not enroll in Medicare Part A when eligible</li> <li>• The end of the month where Retiree or Same-Sex Domestic Partner is present unlawfully in the U.S. while eligible for Medicare</li> <li>• Same-Sex Domestic Partner’s death</li> </ul>
<b>Dependent Children</b>	<ul style="list-style-type: none"> <li>• On the date the Retiree’s coverage begins;</li> <li>• On the date the Dependent is acquired, if reported within 30 days of event; or</li> <li>• If later than 30 days after the event, the first of the month following the date of notice.</li> </ul>	<ul style="list-style-type: none"> <li>• When the Dependent no longer meets the Plan’s eligibility rules</li> <li>• The date the Dependent is removed from coverage by the Primary Enrollee</li> <li>• The end of the month for which the last payment was made</li> <li>• The date of the contract under which the Dependent was covered ends</li> <li>• The end of the second month after the month where Retiree or Dependent Child does not enroll in Medicare Part A when eligible</li> <li>• The end of the month where Retiree or Dependent Child is present unlawfully in the U.S. while eligible for Medicare</li> <li>• Dependent Child’s death</li> </ul>
<b>Surviving Spouse or Surviving Same-Sex Domestic Partner</b>	In the case of the Retiree’s death (or death of active employee who is eligible to retire), coverage as a Primary Enrollee begins the first of the month following the month of death	<ul style="list-style-type: none"> <li>• The date of death of the Surviving Spouse or Surviving Same-Sex Domestic Partner</li> <li>• The end of the month for which the last payment was made</li> <li>• The end of the second month after the month where Surviving Spouse or Surviving Same-Sex Domestic Partner does not enroll in Medicare Parts A or B when eligible</li> <li>• The end of the month where Retiree or Dependent Child is present unlawfully in the U.S. when eligible for Medicare</li> </ul>

\* Individuals whose coverage stops may be eligible for COBRA. (See COBRA Continuation Coverage Section IX sub-section A)

8 † All coverage will end on the date the Plan or Trust is terminated.

## **F. YOUR CONTRIBUTION**

The Contribution is the amount a Primary Enrollee is required to pay, on a monthly basis, for participation in the Plan. The amount may vary depending on enrollment factors such as family size, Protected status, or enrollment option. The monthly Contribution is due on the first day of each month. The payment of a monthly Contribution is required to participate in the Plan, regardless of the level of benefits selected (e.g., the Contribution is the same whether you wish to have prescription drug coverage or dental coverage under the Plan).

The Trust will obtain the required Contributions through pension deduction. However, if you are eligible for coverage but not receiving a pension, or are unable to pay required Contributions from your pension, you may elect to make payments through direct debit (from your bank) or pay via invoice.

## **G. TERMINATION FOR NON-PAYMENT OF CONTRIBUTION**

If you do not pay your Contribution or have the Contribution direct debited from a bank account with insufficient funds, the Plan will provide you with notice of non-payment. You should pay the past-due amount immediately. If you do not pay your Contribution, the Plan will terminate your coverage. Any claims you or your Dependents incurred while you are not enrolled in the Plan are your responsibility, unless you make up all missed Contributions. You may be allowed back into the Plan at a later date by agreeing to have the Contribution automatically deducted.

## **H. TERMINATION FOR FRAUD**

If you or your Dependents commit fraud or deliberately make misleading statements to the Plan, you and your Dependents may have your coverage terminated on the date the fraud occurred. Knowingly enrolling an individual that is not eligible for coverage under the Plan is fraud, and if you enroll such an individual, you and your Dependents will lose your coverage. Any claims the Plan pays because of fraud will become your responsibility to pay.

## **I. TERMINATION FOR FAILURE TO HAVE MEDICARE PART A**

If you or your Dependents become eligible for Medicare Part A, you must enroll in Medicare Part A. You (as with most Enrollees) most likely will be eligible upon turning 65. You should also enroll in Medicare Part B (see the later section on the Plan's treatment of your claims when you could have Part B, but do not). If you choose not to enroll in Medicare Part A when you are first eligible, the Plan will terminate your coverage. This provision does not apply in two situations:

- If you (or your Dependent) first became eligible for Medicare prior to January 1, 2017; or
- If you (or your Dependent) become eligible on the basis for End Stage Renal Disease.

## **J. TERMINATION FOR UNLAWFUL PRESENCE**

If you or your Dependents become eligible for Medicare, and at the same time, are present in the U.S. illegally, the Plan will terminate your coverage. See the Reinstatement section earlier in this document as to how you can reinstate your coverage if your residency in the U.S. becomes legal.



## II. HEALTH PLAN OPTIONS

The Plan provides coverage to you and your eligible Dependents for a wide range of health care benefits. Your health care services are provided through the specific medical plan option you elect for yourself and your Dependents. You will have different options available to you depending on your permanent address and your Medicare enrollment status. Availability of most plan options is negotiated annually and, with the exception of the Traditional Care Network (TCN) and the Enhanced Care PPO (ECP) plans, may not always be offered in the next year.

### A. PLAN OPTIONS FOR NON-MEDICARE ENROLLEES

#### 1. Enhanced Care PPO (Preferred Provider Organization) (ECP) Option

The ECP plan is the base plan available to all non-Medicare Plan members in all 50 states. The Plan strives to offer other options, but it is not required to offer other plan options besides the ECP option. The ECP plan is based on a nationwide network of Providers. This option allows services to be performed both in-network and out-of-network.

Because the Plan does not cover all health care expenses, you should seek guidance from the Carrier of your specific health care plan (for example, Blue Cross Blue Shield) to determine if a particular service or supply is covered or if a Provider is In-Network. You should find out whether the service, device, treatment, or other item is covered before receiving the service.

**The ECP option is the base plan available for non-Medicare members in all 50 states.**

The ECP plan offers network flexibility, which allows you to receive services from both In-Network Providers and Out-of-Network Providers. To receive the highest level of benefits with the least out-of-pocket cost to you, you need to receive services from Providers who participate in the network of the health plan in which you are enrolled. Providers who are contracted with a health plan are called In-Network Providers. In-Network Providers have agreed to accept the Carrier's contracted amount, or Allowed Amount, as payment in full for services you receive (subject to applicable Deductibles, Coinsurance, and Copayments).

If you choose to receive care from an Out-of-Network Provider, you will be responsible for additional costs, with some exceptions. You will likely be responsible for higher out-of-network Deductibles, Coinsurance, and Copayments, and any amount where the Out-of-Network Provider's charges are higher than the Plan's discounted rate (Allowed Amount) for the service received. It's important to note that any amount over the Allowed Amount, as determined by the Carrier, does not count toward your Out-of-Pocket Maximum.

## 2. Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) is a health care delivery system that emphasizes preventive health care and early treatment, in addition to providing medically necessary care when you are sick. HMOs under the Plan are only offered in limited areas. HMOs provide you with claims coverage through a network of providers. Copayments are required for certain services. You choose a primary care physician or facility from a list provided by the HMO, and that physician or facility coordinates all your health care needs. The scope and level of benefits and coverage provided by an HMO may differ from other plan options contracted with the Plan.

In order for services to be covered by the HMO, you must receive the services from HMO Network Providers. Non-emergency services obtained from Providers outside of the HMO Network are NOT covered at all unless the HMO preauthorizes treatment after a request from your primary care physician. Emergency services and urgent care are covered (subject to the HMO's rules).

Various HMO offerings may be available to you under the Plan based on where you live, your Medicare status, and other factors. When you become eligible for Medicare, you will be placed into the Medicare Advantage (MA) plan associated with your current HMO. For more information about the HMO option(s) in your specific geographic area, contact Retiree Health Care Connect.

## **B. PLAN OPTIONS FOR MEDICARE ENROLLEES**

### 1. Medicare Advantage Option

Medicare Advantage (MA) Plans are health plan options approved by Medicare and administered by private companies (Carriers). MA Plans provide all of your Medicare Part A (hospital) and Part B (medical) benefits.

MA Plans are the primary plan for Medicare members. This means, at the end of the year in which you (or one of your Dependents) enroll in Medicare, the Plan will inform you that you (or the Medicare Dependent) will be automatically enrolled into an MA PPO plan on January 1, following the year you qualify for Medicare unless already enrolled in a MA plan. You will be given an opportunity to opt out of this placement and continue in your current plan option.

In order to enroll in an MA plan, members must be enrolled in Medicare Parts A and B. If you wish to enroll in an MA plan prior to the end of the year in which you turn 65, you may do so by calling Retiree Health Care Connect. The MA plan available to you depends on your permanent address. You must continue to pay your Medicare Parts A (if required) and B premiums. However, MA Plans may have different Deductibles, Copayments, and Coinsurance than other available options.

Also, MA Plans may offer additional benefits, services, and programs not provided under Parts A and B of Medicare (such as care management programs and wellness programs). Most MA Plans have Provider networks, so you will be required to see specific doctors and use specific hospitals.

## 2. Traditional Care Network (TCN) Option

The TCN plan is a plan available to all Plan members enrolled in Medicare in all 50 states. The Plan strives to offer other options, but it is not required to offer other plan options besides the TCN option. The TCN plan is based on a nationwide network of Providers. For members in this plan, Medicare is primary and TCN coverage is secondary. This option allows services to be performed both in-network and out-of-network.

Because the Plan does not cover all health care expenses, you should seek guidance from the Carrier of your specific health care plan (for example, Blue Cross Blue Shield) to determine if a particular service or supply is covered or if a Provider is In-Network. You should find out whether the service, device, treatment, or other item is covered before receiving the service.

The TCN plan offers network flexibility, which allows you to receive services from both In-Network Providers and Out-of-Network Providers. To receive the highest level of benefits with the least out-of-pocket cost to you, you need to receive services from Providers who participate in Medicare as well as in the network of the health plan in which you are enrolled. Providers who are contracted with a health plan are called In-Network Providers. In-Network Providers have agreed to accept the Carrier's contracted amount, or Allowed Amount, as payment in full for services you receive (subject to applicable Deductibles, Coinsurance, and Copayments). If the service you are receiving is a Medicare-covered service, you should be receiving care from a provider participating with Medicare.

If you choose to receive care from an Out-of-Network Provider, you will be responsible for additional costs, with some exceptions. You will likely be responsible for higher out-of-network Deductibles, Coinsurance, and Copayments, and any amount where the Out-of-Network Provider's charges are higher than the Plan's discounted rate (Allowed Amount) for the service received. It's important to note that any amount over the Allowed Amount, as determined by the Carrier, does not count toward your Out-of-Pocket Maximum.

If you choose to receive care from an Out-of-Network Provider who does not participate in TCN, you will be responsible for sharing additional costs unless the service is for emergency care or you receive an authorized referral. For those services that require a referral, you need to receive the referral from an In-Network Provider who participates in the network before receiving covered services from an Out-of-Network Provider.

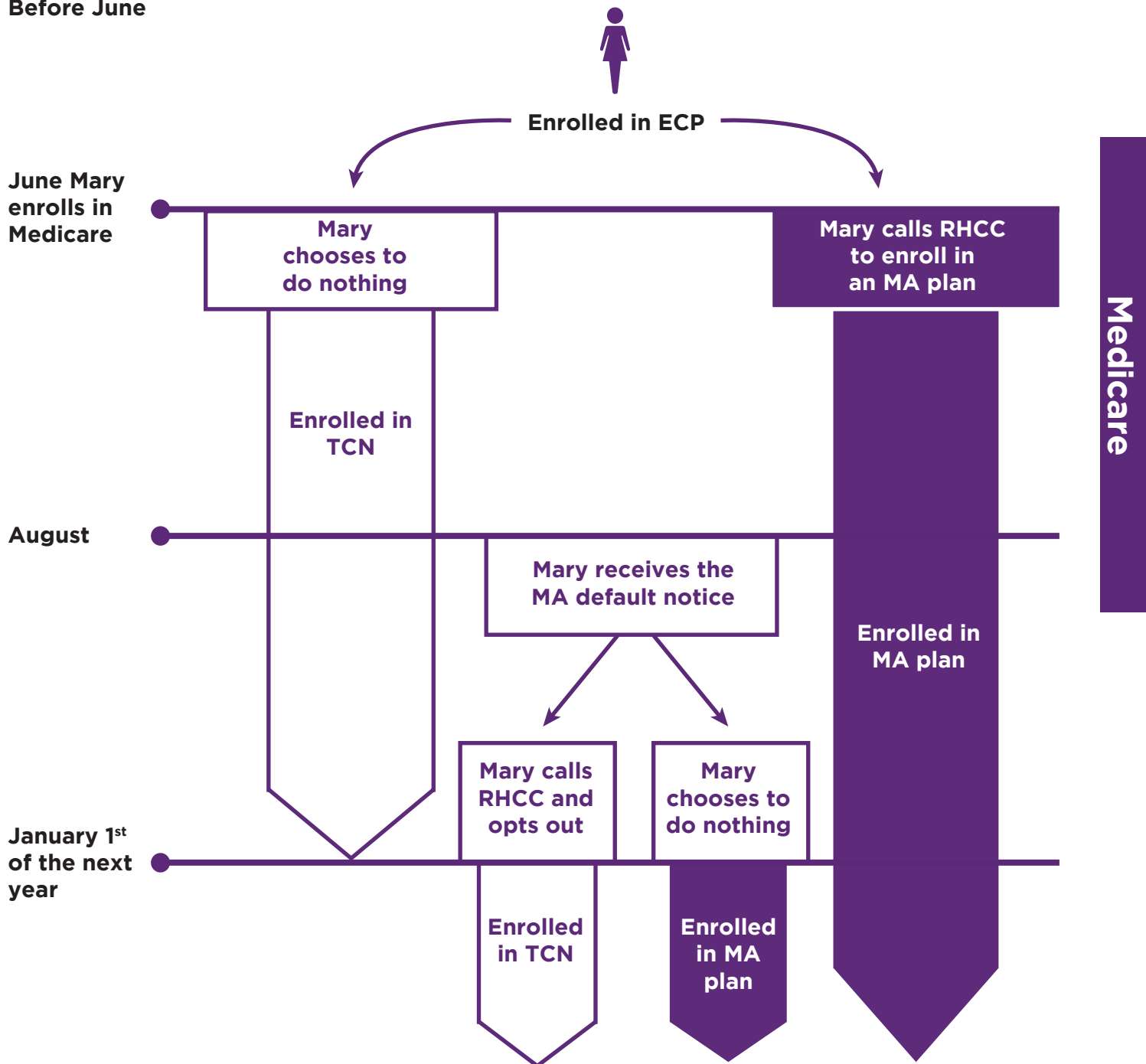
**If you are enrolled in either the Enhanced Care PPO or Traditional Care Network plan, your benefits will be described in more detail in this SPD. If you select a Health Maintenance Organization (HMO) or Medicare Advantage (MA) plan, you will receive a separate booklet from your Carrier that will describe your benefits and how to access them.**

**In order to be covered by the Plan, you can only enroll in health plan options with which the Plan has contracted.**

### 3. Illustrative Example on Medicare Enrollment

Mary is enrolled in the ECP plan until she turns 65 in June. She is able to enroll in Medicare beginning in March (see the next Chapter for more information on Medicare eligibility). When she enrolls in Medicare, she will be offered the choice by the Trust to opt-in to a Medicare Advantage (MA) plan by calling Retiree Health Care Connect. If Mary does not call Retiree Health Care Connect, she will be placed into the TCN plan until the end of that year. At the end of the year when she turns 65, Mary will receive notice that she will be enrolled into an MA PPO plan unless she calls and opts out. If she opts out, she will remain in the TCN plan. If Mary does nothing, she will be enrolled in the MA PPO plan beginning January 1st.

**Before June**



## C. PLAN OPTION RULES

### 1. Rolling Enrollment – Changing Your Plan Option Election

You may change your Plan elections at any time of the year, provided 12 months have elapsed since your last election change and you remain eligible for coverage. To make a change, call Retiree Health Care Connect. The change generally will take effect on the first day of the second month following the month Retiree Health Care Connect receives the election (for example, June 1 if your election is made in April).

Once you make a change to your Plan elections, you must wait 12 months to make another change (unless the Plan notifies you of an additional opportunity). Exceptions may be allowed prior to the 12-month period based on certain life events (permanent address change, adding or removing a dependent from coverage, becoming Medicare eligible) or if a new plan becomes available in your area.

Disenrollment from a Medicare Advantage plan is allowed at any time. The disenrollment will be effective the first of the month following the request.

### 2. Plan Option for Families with Medicare and Non-Medicare Enrollees

Households consisting of members enrolled in Medicare coverage and others who are not enrolled in Medicare (known as a “Split Family”) are allowed to split medical plan elections between available non-Medicare and Medicare plan options. For example, when you or one of your Dependents becomes eligible for Medicare, that member (the one enrolled in Medicare) will be offered alternative plan options. The remainder of your family may continue to be enrolled in their current plan option. When all members of a family are enrolled in Medicare (or all not enrolled in Medicare), they must all select the same plan option.



# III. INTRODUCTION TO MEDICARE

## A. BACKGROUND ON MEDICARE

Medicare is a federal health care program for individuals age 65 or older, and for certain individuals under age 65 who have a severe long-term disability, end-stage renal disease (ESRD), or undergo a kidney transplant. Medicare has four parts:

1. Medicare Part A – Hospital Insurance. Part A helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some home health care, and hospice care. Generally, there is no monthly premium, but there are deductibles for inpatient stays and coinsurance or copayments after certain lengths of stay. **You must enroll in Part A when you are first eligible to remain eligible for Plan coverage. Cancelling Part A will have the same effect as if you failed to enroll when first eligible.**
2. Medicare Part B – Medical Insurance. Part B helps pay for doctors' services, including preventive care, and many other medical services and supplies that are not covered by Part A. Part B requires payment of a monthly premium, as well as Deductibles and Co-insurance. **You must enroll in Part B when you are first eligible in order to avoid financial penalties, higher out-of-pocket costs, and a potential delay in your enrollment in Part B. Individuals may purchase Medicare Part B, even if they are not eligible for premium-free Medicare Part A.**

Together, Medicare Parts A and B are called “Original Medicare” or “Traditional Medicare” at times, as those parts were the first parts to be created.

3. Medicare Part C – Medicare Advantage Plans. People with Medicare Parts A and B can choose to receive all of their health care services through one of these plans. A Medicare Advantage Plan covers everything that Original Medicare covers plus generally some additional benefits. These health plan options have been approved by Medicare and are administered by private insurance companies (Carriers).
4. Medicare Part D – Prescription Drug Coverage. Part D helps pay for medications that doctors prescribe for treatment. These plans are approved by Medicare and administered by private insurance companies (Carriers). The Trust sponsors a Medicare Prescription Drug Plan under Part D for you and other Medicare-eligible members. This Part D Plan is described in greater detail later in Section V.

Medicare Parts A and B are available for nearly every individual who is age 65 or older and is entitled to receive monthly Social Security benefits or qualified Railroad Retirement benefits. If you are receiving Social Security or Railroad Retirement benefits for at least four (4) months prior to your 65th birthday, you will automatically be enrolled in Part A and be eligible for Part B starting the first day of the month in which you turn age 65. Usually, you will be automatically enrolled in Part A by Medicare, but you should make sure you are enrolled when you turn 65. A few members may also be required to pay a premium for Part A.

You may need to contact the Social Security Administration for enrollment in Medicare Part B, but you may be automatically enrolled in Part B. You should receive your red, white, and blue Medicare card in the mail three months before your 65th birthday if you were enrolled automatically.

Otherwise, it will arrive after you sign up. If you do not receive your new card, you must contact the Social Security Administration at 1-800-772-1213 or visit their website at <http://www.SSA.gov>. The Social Security Administration will deduct the Part B premiums from your monthly Social Security benefits, if possible, or bill you directly if you do not receive Social Security benefits.

If you are not receiving Social Security benefits already, it is **your responsibility** to contact the Social Security Administration to apply for Medicare Parts A and B when you reach age 65. The Social Security Administration suggests that you contact them at least three months before you reach age 65. This will allow sufficient time to process your application so that you will not miss your initial opportunity for enrollment. Additionally, if you wait until the month of your birthday (or the three months following) you will experience a delay in the start of your Medicare benefits. The length of the delay depends on when you sign up. If you do not enroll in Medicare Parts A and B when first eligible, a **financial penalty** will apply, increasing the monthly Medicare Part A or B premium you pay.

Individuals under age 65 who are entitled to disability benefits under the Social Security or Railroad Retirement Acts for at least 24 consecutive months are also entitled to Medicare Parts A and B. Coverage begins on the first day of the 25th month of entitlement to disability benefits and terminates at the end of the month following the month in which the Social Security Administration provides notice of termination of disability benefits (i.e., you are no longer disabled).

Individuals with end-stage renal disease may also be eligible for Medicare Parts A and B. If you are not yet 65 or otherwise disabled, but have end-stage renal disease, you will become entitled to/eligible for Medicare on the first day of the third month following the month when you first started dialysis. If you receive a transplant, your entitlement/eligibility for Medicare will start two months before the transplant. If you perform self-dialysis, your entitlement/eligibility for Medicare starts the month that you begin your dialysis.

If you are not eligible for Medicare Parts A and B on your 65th birthday, or you lose your eligibility due to circumstances outside of your control, please contact Retiree Health Care Connect (RHCC) to report your situation.

## **B. PENALTY FOR FAILURE TO TIMELY ENROLL IN MEDICARE**

It is important for both you and your Dependents to enroll in Medicare when first eligible.

**You and your Medicare-eligible Dependents must enroll in Medicare Parts A and B.**

Medicare Part A may require a monthly premium. If you fail to enroll when first eligible, the cost of the Medicare Part A premium will go up 10 percent. You will have to pay that penalty for **twice the number of years** you could have had Part A but did not sign up.

Medicare Part B requires a monthly premium. If you fail to enroll when first eligible, the cost of the Medicare Part B premium will go up 10 percent for each full 12-month period you were eligible for Medicare Part B during the initial enrollment period but did not enroll. **This penalty does not expire.**

If you did not enroll when first eligible or opted out of Parts A and B, or cancelled your enrollment, and later choose to enroll, you must wait until the next Medicare Parts A and B open enrollment period, which is January 1 through March 31 of each year. Your Medicare coverage will be effective on July 1 of the year you enroll.

You may not be required to enroll in Medicare Part B if you are covered under other insurance, such as through your or your Spouse's current employer. You will not be penalized for late enrollment in Medicare Part B if you enroll as soon as you lose the other coverage. However, to remain covered under this Plan, you must be enrolled in Medicare Part A when eligible. You should also be enrolled in Medicare Part B, when eligible, in order to receive maximum benefits under the Plan.

If your household income exceeds certain limits described by Medicare, you will be responsible for additional amounts for your Part B premium as well as an additional monthly amount to have Part D (this amount is called the Part D Income-Related Monthly Adjustment Amount). These amounts are paid to the Social Security Office, and the Plan has no control over them.

## **Medicare Information for Medicare-Eligible Retirees, Dependents, and Surviving Spouses / Same-Sex Domestic Partners**

All members of the Plan should enroll in both Medicare Parts A and B as soon as you are eligible. **If you are eligible for and/or entitled to Medicare, your benefits under the Plan will be paid as if you had Medicare coverage, whether or not you choose to enroll in Medicare.** To avoid paying additional out-of-pocket medical expenses, be sure to enroll in Medicare Parts A and B. Individuals may be eligible to purchase Medicare Part B, even if they are not eligible for premium-free Part A. All members are required to enroll in Medicare Part A when they first become eligible for Part A, unless that eligibility first occurred prior to January 1, 2017.

The Trust provides outpatient prescription drug benefits to Retirees and Dependents who are eligible for Medicare under a Trust-specific Part D plan, explained more fully in Section V. However, if you or your Dependents enroll in a non-Trust sponsored Medicare Part D Prescription Drug Plan, your prescription drug benefits under the Plan will be terminated.

## IV. COVERAGE WHEN YOU HAVE MEDICARE

The Plan enhances your coverage under Medicare when you are enrolled in the Traditional Care Network (TCN) Option. The Plan will generally cover the balance of the cost of services that Medicare does not cover. You will be responsible for the applicable Deductible, Coinsurance, and Copayments associated with the Plan.

NOTE: If you are enrolled in a Medicare Advantage plan, this section does not apply to you. You should consult with your Carrier for more information about your medical benefits.

This section will explain to you in more detail about how the TCN Option works with Medicare.

### A. MEDICARE COST SHARING FEATURES

Medicare Part A and Part B requires that beneficiaries pay part of the cost of coverage and part of the cost of health care services. These amounts may be adjusted annually, and a full list of all the amounts is available in the most recent copy of the Medicare & You guide, which you may have received in the mail, but can download at <http://www.medicare.gov> or obtain by calling 1-800-MEDICARE (1-800-633-4227).

**A Deductible is a fixed amount of money you pay annually before the benefit plan begins paying its portion of your medical costs. Generally, services that do not have copays will apply toward your deductible.**

You must pay the Part B premium, the Part A premium (if you have one), and the Income Related Monthly Adjustment Amount (IRMAA) (if applicable) each month.

You also pay a Part A deductible (for example, when you enter the hospital) and a Part B annual deductible before Medicare pays anything towards your health care services (with certain, limited exceptions). The Trust counts any payment you make towards those deductibles as payment toward the Plan's deductible.

If you have questions regarding premiums or Medicare cost-sharing amounts, please contact the Social Security Administration at 1-800-772-1213 or visit their website at <http://www.SSA.gov>.

### B. CONSEQUENCES FOR FAILURE TO ENROLL IN MEDICARE

**You MUST Enroll in Medicare Parts A and B as soon as you are Eligible.**

You (or your Dependents) are required to enroll in Medicare Part A when you are first eligible. An eligible Surviving Spouse/Surviving Same-Sex Domestic Partner who turns 65 must also enroll in Medicare Part A and Part B when first eligible. If you do not, the Plan will terminate your coverage two (2) months after the month in which you turn 65. Upon being enrolled in Medicare after such a termination and contacting Retiree Health Care Connect (RHCC), Plan coverage will restart at your Medicare effective date.

When you are eligible for Medicare Part B, the Plan pays claims as if you are enrolled in Medicare, whether or not you are. Even if you have an exception to the Part B Late Enrollment Penalty (because, for example, your spouse is currently employed and covering you), the Plan still expects you to enroll in Part B and will treat your claims as if you have done so. This means that if you are eligible for, but not enrolled in Medicare, you will have significantly higher out-of-pocket medical expenses.

**EXAMPLE:**

Here is a simple example of why it is important for Medicare-eligible individuals to enroll in Medicare Part B coverage.

Assume Sam, a Medicare-eligible Retiree, requires a medical service and Sam's provider charges \$150 for it.

Assume that Medicare's allowed amount

for the service is \$100, that Medicare would pay 80% of the allowed amount and that the Plan would pay the 20% coinsurance. If Sam is enrolled in Medicare Part B, and has satisfied the Part B and Plan deductibles, the Plan would pay \$20 because Medicare would have paid \$80, and the claim would be considered paid in full. If Sam is eligible for, but not enrolled in Medicare Part B, then the Plan will still pay \$20, and Medicare will pay nothing. Sam, therefore, must pay \$130 (\$150 minus \$20 paid by the Plan).

**The Trust will not pay amounts that Medicare would have paid. You will be responsible for paying these amounts. IMPORTANT: This may be different from previous coverage if you were eligible for Medicare and actively employed.**

These rules will not apply to you if you are eligible for Medicare based solely on a diagnosis of end-stage renal disease for the first 30 months of your Medicare eligibility. If you are eligible for Medicare based on end-stage renal disease, you should still enroll in Medicare

## **C. MANDATORY MEDICARE ENROLLMENT FOR SURVIVING SPOUSES/SURVIVING SAME-SEX DOMESTIC PARTNERS**

An eligible Surviving Spouse/Surviving Same-Sex Domestic Partner who turns 65 must enroll in Medicare Part A and Part B when first eligible.

Coverage will be terminated for Surviving Spouses/Surviving Same-Sex Domestic Partners if they are eligible, but not enrolled in Medicare Parts A and B when the Surviving Spouse/Surviving Same-Sex Domestic Partner coverage begins. When the Surviving Spouse/Surviving Same-Sex Domestic Partner provides evidence of enrollment in Medicare Parts A and B, coverage will be reinstated effective the date Medicare begins.

## **D. HOW MUCH THE PLAN PAYS WHEN MEDICARE ALSO COVERS YOU**

For Retirees and their Medicare-eligible dependents, Medicare is the primary payer of benefits and the Plan is secondary. This means that claims are filed with Medicare first. After Medicare has processed the claim, the remaining balance is submitted to the Plan's Carrier, which determines if the services are covered by the Plan. If they are covered, the Plan pays secondary.



Medicare, while you have coverage under the Plan, the amounts Medicare paid – or would have paid – are excluded for payment under the Plan. Those amounts are your responsibility.

Medicare and the Plan will not always cover all of your health care costs; in some cases, Medicare may cover some expenses that the Plan does not, and, in other cases, the Plan may cover expenses not covered by Medicare. Some services may not be covered by Medicare or the Plan.

NOTE: If you are entitled to Medicare due to end-stage renal disease (ESRD), these rules may not apply during the 30-month Coordination Period (the first 30 months following the beginning of dialysis or a kidney transplant). Please contact your Plan's Carrier for a description of how the Plan coordinates payment in this situation.

Here is an example of the benefit calculation when Medicare is the primary plan:

- George is a UAW retiree. He is 70 years old and is enrolled in Medicare Part B.
- When George has Part B covered services provided, Medicare is the primary plan and the Trust Plan is the secondary plan.
- The allowed amounts and deductibles are for illustrative purposes only.

**The following example assumes the Plan deductible has not been satisfied:**

<b>Medicare allowed amount</b>	<b>\$1200</b>
<b>Less Medicare Part B deductible</b>	<b>-185</b>
<b>Balance</b>	<b>1015</b>
<b>Medicare pays 80%</b>	<b>-812</b>
<b>Medicare coinsurance (20%)</b>	<b>203</b>
<b>Total amount not paid by Medicare (\$185.00 Medicare Part B deductible plus \$203 Medicare coinsurance)</b>	<b>\$388</b>

**The claim is then considered for benefits under George's Trust plan:**

<b>Medicare allowed amount</b>	<b>\$1200</b>
<b>Amount Medicare paid</b>	<b>812</b>
<b>Amount not paid by Medicare (\$185 Medicare Part B deductible + \$203 Medicare coinsurance)</b>	<b>388</b>
<b>Less the Plan Deductible [Paid by George]</b>	<b>-400</b>
<b>Balance</b>	<b>0</b>



<b>Less the 10% in-network Plan Coinsurance [Paid by George]</b>	<b>-0</b>
<b>Trust secondary payment amount [Paid by the Plan]</b>	<b>0</b>
<b>Total payment for services (Medicare + Plan)</b>	<b>812.40</b>
<b>George's Total Payment (Plan Deductible + Coinsurance)</b>	<b>\$388</b>

In this example, Medicare paid total benefits of \$812. George paid the remainder, which counted against his Plan Deductible. Once George meets his Plan Deductible, the Plan will pick up the difference.

**The following example shows the secondary payment calculation when the Medicare and plan deductibles have been satisfied:**

<b>Medicare allowed amount</b>	<b>\$1200</b>
<b>Less Medicare Part B deductible (Previously Met)</b>	<b>-0</b>
<b>Balance</b>	<b>1200</b>
<b>Medicare pays 80%</b>	<b>-960</b>
<b>Total amount not paid by Medicare (\$240 Medicare coinsurance)</b>	<b>\$240</b>

**The claim is then considered for benefits under George's Plan. The following calculation is used:**

<b>Medicare allowed amount</b>	<b>\$1200</b>
<b>Amount Medicare paid</b>	<b>960</b>
<b>Amount not paid by Medicare</b>	<b>240</b>
<b>Less Plan deductible (Previously Met)</b>	<b>-0</b>
<b>Balance due for services</b>	<b>240</b>
<b>Less the 10% in-network Plan Coinsurance [Paid by George]</b>	<b>-24</b>
<b>Plan secondary payment amount [Paid by the Plan]</b>	<b>216</b>
<b>Total payment for services (Medicare \$960 plus Plan \$216)</b>	<b>1176</b>
<b>George's Total Payment (Coinsurance)</b>	<b>\$24</b>

In this example, Medicare paid total benefits of \$1176.

## E. VISITING YOUR HEALTH CARE PROVIDER

Whenever possible, you should select a provider who participates with Medicare, sometimes known as one who “accepts assignment” from Medicare. This means that the Providers accept Medicare’s Allowed Amount for services and cannot bill you for any amounts above the Allowed Amount. By choosing a provider who accepts assignment from Medicare, you can keep your out-of-pocket costs as low as possible. If you choose to go to a Provider that does not “accept assignment” under Medicare or a Provider that does not accept Medicare patients, the Plan, at most, will only pay what it would have paid if you had gone to a Provider that accepted Medicare. The Plan may not cover the service at all with some Providers.

**You must use a Provider that accepts payment from Medicare to get the most from your benefits.**

In certain areas of coverage, such as durable medical equipment or diabetes supplies, Medicare has contracted suppliers. You should use the Medicare contracted supplier for durable medical equipment and diabetes supplies covered by Medicare. Each of these is described in more detail later in this section.

Some of the Providers that do not accept assignment under Medicare will still accept payment from Medicare, but require their patients to submit the claims to Medicare on their own, as well as potentially charging the patients up to 15% above the Medicare allowed amount, which Medicare will not pay. The Plan will not cover this 15%, but may pay part of your cost-sharing obligations after Medicare pays and subject to the Plan’s own cost-sharing for which you are responsible.

Some Providers opt out of Medicare and require Medicare patients to sign an agreement stating that the patient understands that Medicare will not pay. **You should be wary of these agreements** and these Providers, particularly if you are seeking services that Medicare normally covers (such as a wellness visit or a diagnostic test). The Plan may not cover these Providers at all, or will, at the most, pay what the Plan would have paid had you gone to a Provider that participates in Medicare.

To find out if your current physicians, laboratories, and other service providers “accept assignment” under Medicare, you should ask them specifically whether they “accept assignment” before receiving services.

## F. MEDICARE COVERAGE FOR PREVENTIVE SERVICES

Medicare covers many health care services to prevent or detect illness at an early stage, when treatment is likely to work best. Services that Medicare considers “preventive” are offered at no cost. Visit <http://www.medicare.gov> for a list of preventive services.

## G. OFFICE VISITS UNDER MEDICARE

Currently, Medicare covers one “Welcome to Medicare” visit and a yearly “Wellness” visit for all Medicare beneficiaries with their primary care doctor. Medicare beneficiaries receive this visit at no cost. Medicare beneficiaries can receive other office visits beyond this first one at no cost if they are for preventive services.

Medicare will cover 80% of the cost of office visits if they are for non-preventive services or care. The Plan does not cover any portion of these visits. You are responsible for the remaining 20% that Medicare does not cover. Also, the Plan does not pay for office visits for Medicare members that Medicare does not cover.

Medicare will also cover “Advance Care Planning,” which may be conducted during an office visit or may occur separately. Advance Care Planning is a discussion between you and your doctor about future plans for a particular illness you have. These discussions are intended to assist you in making decisions about how you wish to treat your current health conditions.

## **H. SKILLED NURSING FACILITY STAYS**

A Skilled Nursing Facility (SNF) is a facility outside of the hospital that provides nursing care 24 hours a day under the supervision of a Physician and a registered nurse. Following a three-day inpatient admission to a hospital, Medicare will cover you for a stay in a Skilled Nursing Facility (SNF) for rehabilitation and further therapy. This stay is limited to 100 days under Medicare Part A. The Plan's coverage of 100 days does not add on to this time limit for a SNF stay. Instead, the Plan will cover the daily copayment for Days 21 through 100. Both the Plan and Medicare require that you stop receiving SNF services for a period of 60 days before further SNF coverage is possible. If you require additional SNF days after those 60 days, you will need to have a 3-day inpatient admission in order for Medicare to cover additional SNF days (up to 100 again). The Plan will cover your copayments for Days 21 through 100 during that stay. You will also have coverage for another 100 days for SNF care under the Plan at the beginning of each Plan Year.

## **I. EYE CARE UNDER MEDICARE**

The Plan offers routine and diagnostic vision care. Medicare does NOT cover routine eye exams, eye refractions (exams that measure how well you see at specific distances), or, in most cases, eyeglasses.

Certain eye care-related services or items are covered by Medicare Part B, subject to the Part B deductible and coinsurance. The Medicare covered services/items include:

- Diabetic Eye Exam – To check people with diabetes for diabetic retinopathy. Covered once every 12 months.
- Glaucoma Screening – To check people with diabetes or others at high risk for glaucoma. Covered once every 12 months.
- Treatment of Macular Degeneration – A treatment for some patients with age-related macular degeneration.
- Eyeglasses Following Cataract Surgery – One pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens.

The Plan may cover routine and diagnostic vision services that Medicare does not. Vision benefits are described in more detail later in this book. Contact information for the vision benefit Carrier is at the end of this SPD.

## J. MEDICARE COVERAGE FOR DIABETIC CARE

If you receive treatment for diabetes from a health care Provider who accepts Medicare, Medicare will cover both treatment and preventive care services. These include:

### 1. Diabetes Screenings

Diabetes screenings are covered by Medicare if you have any of the following risk factors: high blood pressure, history of abnormal cholesterol and triglyceride levels, obesity, or a history of high blood sugar. Medicare also covers diabetes screenings based on certain other risk factors, and you may be eligible for as many as two screenings each year.

### 2. Diabetes Self-Management Training

Your health care Provider must provide a written order for training offered by certified diabetic educators. The Plan will cover your portion of the coinsurance under Original Medicare.

### 3. Diabetes Supplies

Medicare Part B covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Insulin is covered if used with an insulin pump under Part B. Insulin in other forms may be covered under the Part D plan.

The Plan covers your cost-sharing for approved diabetes supplies. The Plan will only cover these supplies when provided by Medicare approved suppliers. To find a Medicare-approved supplier, visit <http://www.medicare.gov/supplier> or call 1-800-MEDICARE (1-800-633-4227).

Medicare benefits may change annually, so you should ask your Carrier about your benefits when you receive services. If you are enrolled in a Medicare Advantage Plan, your benefits may be different. Contact your Carrier to determine how treatment related to diabetes is covered under your Plan option.

## K. MANDATORY CASE MANAGEMENT

In some instances, you may be required to participate in mandatory Case Management. The Plan, working through your Carrier, may require Case Management participation for certain conditions that are complex, severe, or rare.

If a member refuses to participate in mandatory Case Management, the Plan's portion of the financial obligation for all medical services, treatments, situations, prescription drugs, or other services related to the condition may not be covered. For Enrollees enrolled in Parts A and B of Medicare, Medicare will continue to cover its portion of the financial obligation as Case Management is not required by Original Medicare. In that case, even though Medicare may cover its portion, the Plan will not cover the remaining portion of any claims.

## L. HUMAN ORGAN TRANSPLANTS

Coverage for transplants is limited to only those approved by Medicare and performed at Medicare-approved facilities. Medicare will cover the transplant, and the Plan will cover any related Medicare cost-sharing if you are enrolled in Case Management. You may still have some Plan cost-sharing associated with the transplant.

Enrollment in Case Management is required for all transplant types except cornea, skin, or kidney (unless the kidney is transplanted alongside another organ such as a pancreas). If you do not participate in Case Management, the Plan's portion of Medicare cost-sharing for all transplant services, treatments, situations, prescription drugs, or other services related to the transplant will not be covered. Your enrollment in Case Management will begin before the transplant surgery is conducted and will continue after the surgery, in order to provide you with the best chance of a successful transplantation.

## M. DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS AND ORTHOTICS (P&O) APPLIANCES

### 1. DME and P&O Coverage

Durable medical equipment (DME) coverage includes, but is not necessarily limited to:

- Equipment that meets Plan standards, which generally include being approved for reimbursement under Medicare Part B and being appropriate for use in the home;
- Repairs necessary to restore the equipment to a serviceable condition as when the equipment was purchased (this does not include routine maintenance);
- Neuromuscular stimulators;
- External electromagnetic bone growth stimulators, in certain approved cases;
- Pressure gradient supports for certain patients;
- Mastectomy sleeve;
- Pronged and standard canes (when purchased, not rented); and
- Continuous Passive Motion Devices (shoulder and elbow) following shoulder or elbow surgery and only for a maximum of 21 days.

**You must use a contracted and approved Medicare Supplier to receive DME coverage.**

**You should make sure any supplier you use is contracted with Medicare.**

Prosthetic and orthotic (P&O) appliance coverage includes, but is not necessarily limited to:

- P&O appliances that are furnished by an accredited facility and meet Plan standards, which generally include being approved for reimbursement under Medicare Part B, and the replacement, repair, fitting, and adjustments of the appliance;
- Therapeutic and orthopedic shoes, inserts, arch supports, and shoe modifications when the shoes are part of a covered brace;
- Hair pieces/wigs (when suffering hair loss from chemotherapy, radiation, or other treatments for cancer);
- Prescription lenses following a cataract operation or an operation to replace a missing lens because of a congenital condition; and
- Appliances or devices that are surgically implanted permanently within the body or those that are used externally while in the Hospital as part of regular Hospital equipment or when prescribed by a physician for use outside the Hospital.

## *2. Approved DME and P&O Suppliers*

In order to avoid additional costs, you must use Medicare-contracted suppliers for any Medicare-covered DME or P&O appliance. You should call 1-800-MEDICARE (1-800-633-4227) or visit <http://www.medicare.gov/supplier> for additional information on which kinds of DME or P&O apply and where you can find an approved supplier.

Coverage, up to the Medicare Allowed Amount, is provided for Medically Necessary DME and P&O appliances prescribed by your doctor. If covered equipment and items are received from a non-approved Medicare supplier, the Plan will not pay any covered amounts in coordination with Medicare and you will be responsible for paying the supplier's full charge as well as any additional amounts that may be incurred.

NOTE: The type of DME and P&O appliances covered are not always consistent (as to brand, type, or design) among approved Medicare suppliers.

You, your physician, or your supplier may contact your Carrier for preauthorization, claims processing, locating Network suppliers, determining approved equipment, and for any other questions or concerns.

You will need to get your diabetic supplies under Medicare from an approved contracted supplier. Consult sub-section J on diabetes supplies for more information.



### 3. Additional Plan DME and P&O Appliance Coverage

The Plan covers some DME or P&O appliances that Medicare does not cover. With these devices, you should follow the requirements in the non-Medicare section of this book as to DME and P&O coverage. These generally include such device being on the Plan-approved list of devices and being supplied by a contracted provider.

The Plan may also cover a device at a supplier not covered by Medicare. This is a rare occurrence, so you should contact your Carrier in advance of receiving the device to see if the supplier you plan to use would be covered by the Plan.

### 4. Exclusions

Certain exclusions apply to the Plan's coverage of DME and P&O appliances. Examples of these exclusions include:

- Deluxe versions of equipment that are not medically necessary;
- Items not medical in nature;
- Physicians' equipment (such as stethoscopes);
- Exercise equipment;
- Hygienic equipment (such as bidets, toilets seats);
- Equipment that has been determined to be Experimental or Investigational;
- Pulse oximeters; and
- Supplies for wound care

## N. PLAN COVERAGE BEYOND MEDICARE

Medicare coverage under Parts A and B has limits on several benefits. For example, Inpatient hospital days, Home Health Care, and Physical Therapy all have such limits. The Plan's medical benefits often match those of Medicare Parts A and B. However, at times, the Plan will cover medical benefits beyond what Medicare Parts A and B covers. A common scenario for this is when the Plan will cover more visits or days in a particular benefit than Medicare. When you reach the Medicare limit, you should refer to the **Benefits for All Enrollees Section** (Section VI) if no sub-section for that benefit appears above. In particular, you should note the Sub-sections on "Hospital Coverage," "Home Health Care Coverage," "Observation Services," and "Outpatient Freestanding Facility."

The Plan's benefits beyond Medicare are still coordinated with Medicare; they are not added to one another. For example, Medicare may not cover your stay as an inpatient in the hospital past the 90th day. The Plan's benefit will give you up to 365 days of care, but the Plan will have coordinated your coverage for those 90 days, which would leave you with 275 days of covered inpatient hospital stay (365 days minus 90 days already covered). During those 90 days, the Plan is covering as secondary any costs not covered by Medicare, and you would pay the applicable Plan cost-sharing.

## O. COORDINATION OF BENEFITS WITH TWO OR MORE PLANS AND MEDICARE

If you are eligible for Medicare, Medicare will generally be the primary payer of health care expenses and the Plan will be the secondary payer. Your claims should be submitted to Medicare first and then to the Carrier for coordination of benefits. Medicare provides some additional benefits, such as office visits for Medicare members, which are not covered by the Plan.

Regardless of whether or not you are enrolled in Medicare Parts A and B, benefits paid by the Plan will be limited to an amount equal to the secondary balance payment that would have been paid if, on the date of services, the enrollee was enrolled in Medicare Parts A and B and received services from a Provider that participates in Medicare.

If your Spouse is eligible for Medicare but chooses not to enroll in Medicare Part B, the Plan will not pay any additional costs that would have been covered by Medicare Part B.

This chart may be helpful.

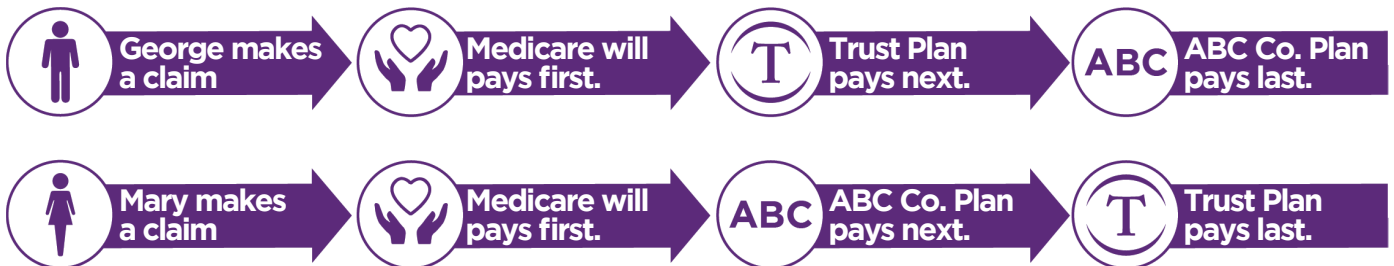


**George:**  
Medicare/Trust  
retiree (policyholder)



**Mary:**  
Medicare/ABC retiree  
(policyholder)

**George and Mary are married and each a dependent spouse on the other's coverage**



If you are covered under the Plan, Medicare, and a Spouse's active employee health coverage as a dependent, your claims will be covered first by the Spouse's active employee health coverage, then by Medicare as a secondary payor, then the Plan as a third payor.

## P. CLAIMS AND APPEALS PROCESS UNDER MEDICARE

To appeal a decision under Medicare, you must follow the Medicare process outlined below. All claims for Medicare enrolled individuals should be submitted to Medicare before being submitted to a Carrier. In many states, a Carrier may have an arrangement with Medicare, so that when Medicare processes the claim, it provides information directly to the Carrier, which then processes the secondary balance. You will receive a combined Explanation of Benefit (EOB) statement that shows how both Medicare and the Plan paid the claim.

This same process is what the Plan uses to evaluate the claims and appeals under the Plan's Part D plan for prescription drugs.

If you are appealing a benefit not covered by Medicare or for Plan eligibility, you should consult the Claims and Appeals sub-section C in Section VIII.

# V. PART D PLAN PRESCRIPTION DRUG COVERAGE

## A. PRESCRIPTION DRUG COVERAGE IN MEDICARE (PART D)

Medicare covers prescription drugs under Part D similarly to how it covers inpatient benefits under Part A and necessary medical services under Part B. What is different about Part D from Parts A and B is that Medicare does not administer the benefit itself. Instead, it contracts with private organizations, very often pharmacy benefit managers or PBMs, to administer the benefit on behalf of Medicare. These “Part D Plans” have an annual review and filing for their benefit design and formulary.

## B. HOW PRESCRIPTION DRUG COVERAGE WORKS UNDER THE PLAN

The Plan has contracted with a PBM to offer a Part D plan to you and other Medicare members. This plan is sometimes referred to as the Employer/Union-sponsored Group Waiver Plan or “EGWP” (pronounced “egg-whip”).

If you are eligible for Medicare and are enrolled in Part A or B, the Plan will automatically enroll you into the Part D EGWP Plan. Before you are automatically enrolled in the Part D EGWP Plan, you will be given an opportunity to “opt out.” However, if you opt out of the Part D EGWP Plan before enrollment or later choose to terminate your enrollment in the Part D EGWP Plan, you will not have any drug coverage under the Plan.

If you “opt out” of the Plan’s Part D EGWP Plan, and do not enroll in a different Part D Plan right away, you will likely be responsible for a late enrollment penalty if you do later enroll. If you mistakenly “opt out,” you will have the opportunity to re-enroll, and should do so as soon as possible. If you “opt out” of the Plan’s Part D Plan, and are not enrolled in one of the Plan’s Medicare Advantage Prescription Drug (MA-PD) plans, any drug costs you incur will be the responsibility of either you or another plan in which you are enrolled.

Be very careful about enrolling in any other drug plan. Since the Plan provides prescription drug coverage for Retirees and Dependents who are enrolled in Medicare, you should not enroll in a non-Trust Medicare Part D Prescription Drug Plan. You will lose your prescription drug coverage under the Plan if you or your Dependents enroll in a non-Trust Part D Prescription Drug Plan.

You can be enrolled in a Plan-sponsored Medicare Advantage (MA) plan with medical coverage only and the Plan’s Part D EGWP Plan. If you are enrolled in a Plan-sponsored MA plan, you cannot choose to enroll in an outside Part D plan (any Part D plan not offered to you by the Trust). If you do so, you will be disenrolled from your MA plan and placed into the Traditional Care Network plan, and you will have no Plan-sponsored drug coverage. Please contact Retiree Health Care Connect (RHCC) if you have any questions about this aspect of your prescription drug coverage.

If you are enrolled in a Medicare Advantage Prescription Drug (MA-PD) HMO plan, this section does not apply to you. You should consult your MA-PD Certificate of Coverage for information about your prescription drug benefits. You cannot be enrolled in an MA-PD plan and this Part D EGWP Plan at the same time.

You can expect to receive a separate prescription drug card and a number of communications from the Part D EGWP Plan describing these benefits in greater detail. There are a few differences and things that you should know about this coverage that are explained in the sub-sections that follow.

The Part D EGWP Plan has a tiered copay structure, 90-day mail order program, and requires prior authorizations for certain medications.

## C. PLAN FORMULARY AND COVERED DRUGS

The Plan's Part D EGWP Plan, like all prescription drug plans, covers a specific list of drugs. This list is called a "formulary" and includes which drugs are covered, which dosage strengths are covered for those drugs, and any limitations the Plan has placed on filling that drug. The formulary for the Part D EGWP Plan is approved by Medicare each year before becoming a part of your Plan. A summary of this formulary will be provided to you annually with the communications from the Part D EGWP Plan.

To determine if a particular drug is covered or not, you should call the PBM whose customer service phone number is listed on the back of your pharmacy benefit ID card.

## D. GENERIC AND BRAND-NAME MEDICATIONS

Prescription drugs are dispensed under two names: the generic name and the brand name. A generic drug is chemically equivalent to a brand drug for which the patent has expired. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

**You will have the lowest out-of-pocket costs if you ask your doctor to prescribe generic drugs whenever possible.**

Generic medications help to control the cost of health care while providing quality medicine – and can be a significant source of savings for you and the Plan. When you receive a brand name medication, you generally pay more because they are more expensive. Your physician or pharmacist can assist you in substituting generic medications when appropriate. Generic drugs have a lower Copayment than brand name drugs. For greater cost-savings, always request that your doctor prescribe a generic drug.

The Part D EGWP Plan places almost all drugs onto "tiers" (or levels) that carry different cost-sharing amounts. The cost-sharing amounts for each tier are listed in the Schedule of Benefits and the most recent Benefit Highlights Letter.

When a brand-name drug is dispensed instead of a generic equivalent version, you will be required to pay a higher Copayment.

If your doctor has not indicated “Dispense As Written” or DAW, your prescription will automatically be filled with a generic drug. If you still want the brand-name drug, you will pay a higher Copayment (so long as the brand-name drug is on the formulary).

Similar to the situation with brand and generic drugs are biologic drugs and biosimilars. Biologic drugs are special kinds of medications developed using living organisms to produce the active substance. Biosimilars are like generic drugs but for biologics. Biosimilars may not be able to be automatically substituted when you get a prescription for a biologic filled, so you should speak to your doctor about the availability of a lower-cost biosimilar instead.

With certain classes of drugs, the Plan will only cover those drugs in that class that are generics. The formulary will list which classes and drugs where this is the case.

## **E. WHERE TO GET PRESCRIPTIONS FILLED**

### *1. Mail Order Pharmacy*

Mail order allows you to purchase up to a 90-day supply of your maintenance prescription drugs. All mail order prescriptions are mailed directly to your home.

To start using mail order, complete the PBM’s prescription order form and mail it to the PBM along with your doctor’s original prescription and the applicable Copayment. You can expect to receive your first filled prescription about two weeks from the time you mail your prescription. If you need a medication right away, make sure your physician provides you with two prescriptions: one prescription for a 30-day supply for use at a retail pharmacy, and a second prescription for a 90-day supply to be sent to the mail order pharmacy. Refills can be ordered using the PBM’s website, calling the PBM, or by mailing in the refill order slip.

When you have a new prescription (regardless of whether you have taken that drug before), you might choose to have that prescription sent directly by your doctor to the mail order pharmacy. The mail order pharmacy would then need to obtain consent from you in order to fill that drug. If you have filled a drug through mail order within the past 12 months, the Plan does not need your consent in that case, and will simply send you your prescription. If the mail order pharmacy asks you for your consent to send you your prescription, you should respond as quickly as possible, in order to avoid any delay in receiving your prescription.

For refills, you can call the PBM, go online to the PBM’s website, or use the PBM mobile application to request a refill of an existing medication.

You may be offered the opportunity to have your prescriptions automatically refilled via mail order. The automatic refill program is voluntary. The automatic refill program information supplied to you will explain the requirements for that program under Medicare rules.

Certain drugs, including specialty drugs, may only be available with a 30-day supply. You should contact the PBM to determine which drugs are only available in a 30-day supply.

To find the contact information for your mail order pharmacy, refer to the PBM in the Contact Information pages at the end of this SPD.

## 2. Retail Pharmacy

You have the option of having your prescriptions filled in-person at pharmacies across the country.

For 30-day supplies, particularly for prescriptions for controlled substances or prescriptions that you and your doctor are still trying to find the right strength, you are encouraged to use the retail pharmacy. For certain prescriptions, the mail order pharmacy may not be allowed to fill them.

You can receive prescriptions for more than 30 days at a retail pharmacy, but it may cost you more.

## **F. PRESCRIPTION DRUG COPAYMENTS**

Your prescription drug copayment amount is based on which tier (level) it is on. These different tier levels are based on whether the drug is generic or brand name and whether the drug is dispensed at a retail pharmacy or at the mail order pharmacy. These copayment amounts are shown by category and tier level in the Schedule of Benefits and the most recent Benefit Highlights letter. Medicare has certain maximums for allowed copayments, but the Plan covers part of the Medicare Copayment, leaving you with a lower Copayment. If the discounted price of the prescription is lower than your copayment, you will be charged the lower amount.

You are encouraged, where possible and appropriate, to use generic drugs, which will be the lowest cost to you.

The Part D EGWP Plan fills drugs at a retail pharmacy or by mail order. You are not required to use the mail order pharmacy, but you could have significant personal savings if you choose to use it.

Medicare Part D does not cover the entire cost of prescription drugs. The Plan fills in this coverage. You will only be responsible for the cost-sharing as described in the Schedule of Benefits or a lesser amount in certain circumstances.

Extra Help is a Medicare-approved program that can help you save on Medicare Part D prescription drug copayment costs. As a Trust member enrolled in Medicare, you may meet certain income and resource limits that make you eligible for significant reductions in the copayments that you owe for each prescription. For more information about this program, you may contact Public Consulting Group at 1-877-522-1061.

## **G. QUALITY AND UTILIZATION MANAGEMENT**

To promote safe and clinically appropriate care, certain prescriptions may be restricted in quantity or may require prior authorization and/or step therapy.

### 1. Quantity Limits

For certain drugs, the amount of the drug that will be covered by the plan is limited. The plan may limit how much of a drug you can get each time you fill your prescription. These limits are based on national standards and current safety guidelines in the medical literature. For example, a particular drug used to treat migraines can only have nine (9) doses dispensed every 28 days.



## 2. Prior Authorization

The Part D EGWP Plan requires a review with a physician to determine if the drug qualifies for coverage under the benefit. Prior authorization may be used to confirm the diagnosis for which the drug is prescribed. If your physician prescribes a drug that requires a prior authorization, the PBM will contact your physician to complete the prior authorization review. As noted below, drugs prescribed for conditions other than what the drug was approved by the FDA to treat are generally not covered.

## 3. Step Therapy

In some cases, you are required to first try certain drugs to treat your medical condition before the Plan will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Plan may not cover Drug B unless you try Drug A first.

## H. PRESCRIPTION DRUG EXPENSE EXCLUSIONS

Prescription drug services, supplies, and medications not covered under the Plan include:

- Drugs not approved by the FDA (certain limited exceptions for off-label use are allowed; contact the PBM for more information);
- Drugs available over-the-counter without a prescription (exception: insulin is covered);
- Drugs labeled “Caution: Limited by federal law to investigational use”;
- Any drug being used for cosmetic purposes, even if it contains a Federal Legend Drug (drugs that require a prescription) (treatment for gender dysphoria will not be considered a cosmetic purpose);
- Medical devices or appliances;
- Charges for more refills than your doctor specifies or refills after a year from the original date of the prescription; and
- Drugs used for treatment of erectile dysfunction or inadequacy.

**Note: Diabetic supplies are covered under Medicare Part B or your medical Carrier’s Durable Medical Equipment (DME) program (e.g., home blood glucose monitor, test strips, etc.). See Section IV sub-section J for more details**

## VI. BENEFITS FOR ALL ENROLLEES

This section describes the medical benefits for all enrollees in the Enhanced Care PPO and the Traditional Care Network. This is a general description only and the provisions of the Plan Document control your eligibility for coverage and specific benefits. Some of the specific terms used in this section are defined under “Quick References” at the end of this SPD.

NOTE: If you are enrolled in an HMO or Medicare Advantage plan, this section does not apply to you. You should consult your Certificate of Coverage or Evidence of Coverage for information about your medical benefits.

**You are responsible for cost sharing through Deductibles, Coinsurance, and Copayments. Consult the Schedule of Benefits or the most recent Benefit Highlights Letter for these amounts.**

### A. COST-SHARING FEATURES OF ALL OPTIONS

You are responsible for paying certain costs of health care coverage, as follows:

1. **Annual Deductible** – the total amount you are responsible for paying each calendar year for covered services prior to the Plan making a payment. Deductibles may vary based on the number of individuals on the coverage. Once the Deductible is met, Coinsurance may apply. Separate “in-network” and “out-of-network” deductibles may also apply.
2. **Coinsurance** – the amount you may be required to pay to a Provider for covered services or supplies after any applicable Deductible(s) is (are) met and until you reach the annual Out-of-Pocket Maximum. Such amount is calculated as a percentage of the Allowed Amount for covered services. If the Coinsurance is 10%, for example, the Plan would pay 90% of the Allowed Amount and you would be responsible for the remaining 10%. The Coinsurance percentages may vary depending on whether or not the services are obtained from In-Network Providers.
3. **Copayment** – a fixed-dollar amount that you will be required to pay to a Provider for specific covered services or supplies (such as office visits, emergency room visits, urgent care, or prescription drugs) at the time the service or supply is provided. You are responsible for any required Copayments, regardless of the status of any applicable Deductibles or Out-of-Pocket Maximums. Copayments generally do not count toward meeting your Plan Deductible or Out-of-Pocket Maximum.
4. **Annual Out-of-Pocket Maximum** – the maximum dollar amount you may be required to pay during a given calendar year for the Deductibles and Coinsurance amounts charged for certain covered services and supplies. Separate “in-network” and “out-of-network” out-of-pocket maximums may apply. Copayments do not apply toward the annual Out-of-Pocket Maximum as noted above.

NOTE: Certain expenses may not be applied toward your Deductible or Out-of-Pocket Maximum. In addition, some expenses may not be paid at 100% even after you meet your Out-of-Pocket Maximum. These are:

- Services for which you pay a Copayment (instead of Coinsurance) (e.g., office visits, urgent care visits)
- Services for which you do not get the required preapproval
- Services denied by the Plan as Experimental or Investigational or not Medically Necessary
- Services not generally covered by the Plan

## **B. ALLOWED AMOUNTS UNDER THE PLAN**

Benefits under this Plan are, unless stated otherwise, covered up to the Allowed Amount of the Plan.

## **C. HOSPITAL COVERAGE**

The Plan covers services and supplies associated with Hospital admissions. Coverage is only for the period that is Medically Necessary for the proper care and treatment of the patient, subject to the maximum benefit period discussed below, and to other Plan provisions. As a condition of coverage, the Carrier may require preapproval of the admission.

### *1. Inpatient Hospital Coverage*

Most services you receive as an inpatient at a Participating Hospital are covered for up to 365 days if preapproved. A stay in a long-term acute care hospital also counts toward your 365 days.

If you were discharged from the hospital, but now need to return and be admitted as an inpatient, the Plan will cover you for the remaining days of your initial 365 days. If you returned home (not to a Skilled Nursing Facility, a Residential Substance Abuse Treatment Facility, long-term acute care facility, or a Hospice) and you were home for at least 60 days, then the Plan will cover another 365 days of hospital care.

If you did not return home, but instead entered an inpatient facility, such as a Skilled Nursing Facility, until you re-entered the hospital, the Plan will cover your hospital stay with the remaining days left of your initial 365.

If you did return home, but you need to re-enter the hospital and you've been out of the hospital for less than 60 days, the Plan will cover your hospital stay with the remaining days left of your initial 365.

In other words, staying out of the hospital and any other inpatient setting for 60 days creates a “reset” of your covered hospital days. This rule is true regardless of why you are returning to the hospital (whether it is related to your original condition or not).

Covered inpatient Hospital services include, but are not limited to, the following:

- Semiprivate room, general nursing services, meals, and special diets. Charges for a private room are covered at the Hospital's standard rate for a semiprivate room, unless a private room is Medically Necessary;
- Medical/surgical supplies, drugs, and medicines;
- Use of operating rooms, other surgical treatment rooms, delivery rooms, and recovery rooms;
- Anesthesia services;
- Blood products and their administration (blood or component preservation and storage for future use are not covered);
- X-rays, EKGs, CT scans, ultrasounds, Magnetic Resonance Imaging (MRI), and Magnetic Resonance Angiography (MRA); and
- Laboratory and pathology services.

## 2. Out-of-Network Hospitals

You may receive services at a Hospital not in the Plan's network. The Plan covers the same services at Out-of-Network hospitals that it does at In-Network hospitals. The difference for you is that you will be responsible for the higher out-of-network cost-sharing.

## 3. Non-Participating Hospitals

The Plan will only cover your services received at a Non-Participating Hospital in a medical emergency. Other than those narrow circumstances, what you pay will depend on coverage that may be available other than that from the Plan (e.g., Medicare, a spouse's insurance), but you could be responsible for the whole cost. Coverage for non-emergency services received at a non-participating hospital will not be provided. Treatment at a non-participating hospital may result in a significant financial obligation on your part. You should determine which hospitals participate with your Carrier before hospital care is needed by calling your Carrier. See the definition of "Participating Provider" for more information.

## 4. Outpatient Hospital Coverage

You may receive some services from a Hospital as an outpatient. These are services that do not require you to be admitted to the Hospital in order to receive them. The services provided include, among others, facility charges, laboratory and radiology services, IV therapy, and nuclear medicine. If you receive a supply of an item in the Hospital as an outpatient (such as a drug or some other supplies), you may be required to use that supply in your treatment before you leave the Hospital in order for the supply to be covered. The Carrier can answer your questions as to whether a particular service is covered and any other questions you may have on the use of supplies used during an outpatient service at a hospital.

## 5. Preapproval

The Plan may require you, your health care Provider, or Hospital to obtain prior approval of all non-emergency, non-maternity hospitalizations and certain other services. Emergency admissions must be reported within 24 hours after the admission. You should inform your Provider or Hospital that preapproval can be obtained by calling the toll-free telephone number printed on your health care identification card.

In two cases, you may be responsible for the cost of the hospital stay related to preapproval.

1. You elected to enter the hospital despite a denial of your preapproval. The Plan will not pay any part of that hospital stay.
2. You elect to stay hospitalized after denied preapproval of your request for an additional stay in the hospital. The Plan will pay for the days in the Hospital until its original preapproval runs out. Then you will be responsible for any days you remain in the hospital.

Remember, the preapproval process determines when and for how long benefits will be payable. The decision about whether to be hospitalized, and for how long, is still up to you and your health care Provider.

The Plan will not restrict benefits for any Hospital length-of-stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. However, this does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The Plan will not require that a Provider obtain authorization from the Carrier for prescribing a length-of-stay not in excess of 48 hours (or 96 hours).

## 6. Observation Services

The Plan will cover your stay in Observation at a hospital and associated services in these circumstances:

- Following an outpatient surgery
- Following emergency room services
- Following an order from a physician's office or a SNF
- Following approval from the Plan

Observation services are used to provide monitoring or active, short-term medical or nursing services to stabilize your condition. Observation services or observation care are considered outpatient hospital services, even when you start out in the emergency room of the hospital. If you are under observation for longer than 24 hours, the copayment for the emergency room will be waived. Coverage for such services are generally limited to twenty-four (24) hours, unless your doctors determine it is medically necessary to hold you longer. Such additional time must be approved by the Plan through the Carrier.

## 7. Emergency Care

Benefits are provided in the case of accidental injuries requiring immediate attention (such as a fracture, severe sprain, concussion, etc.) and qualifying Medical Emergencies.

A Medical Emergency is a health-threatening or disabling condition that requires immediate medical attention and treatment. The condition must be such that if medical treatment is not secured within 72 hours of onset, the patient's permanent health could be in jeopardy or there could be significant impairment of bodily functions. A medical emergency will be covered on the basis of the patient's signs and symptoms, as verified by the physician at the time of treatment, and not on the basis of the final diagnosis.

**Claims will be paid for emergency care if the emergency is a health-threatening or disabling condition that requires immediate medical attention and treatment.**

If you are admitted to the hospital as an inpatient or approved for admittance to an Observation unit for more than 24 hours, your emergency room Copayment will be waived. If you are discharged without being admitted to the hospital as an inpatient, you will be responsible for your emergency room Copayment.

There may be two components of emergency care: Professional Charges – such as for services provided by the treating physician; and Facility Charges – such as for the use of a Hospital emergency room.

- **Professional Charges** – The Plan covers physician services for the initial examination and treatment of conditions resulting from accidental injuries and qualifying Medical Emergencies, wherever the services are administered. Follow-up care after leaving the hospital by the emergency room physician is not covered under the emergency care benefit.
- **Facility Charges** – The Plan covers Hospital emergency room services in Participating and Non-Participating Hospitals for treatment of accidental injuries and medical emergencies.

A Copayment will apply for emergency room treatment, unless the patient is admitted to the hospital. Emergency admissions to the hospital must be reported to the Carrier within 24 hours. Facility and professional charges for follow-up care in an emergency room are not covered.

## 8. Outpatient Freestanding Facility Coverage

Coverage is provided for most outpatient services, such as treatment of accidental injuries and certain Medical Emergencies, surgery, IV infusion therapy, and use of assisted breathing devices or similar equipment.



### 9. Facility Fees

The Plan will cover the facility fee amounts charged by most outpatient facilities and physicians' offices. If you would like to be certain if a given facility's fees would be covered, you should contact the Carrier.

### 10. Urgent Care Centers

Urgent care centers can provide care for certain urgent, but not life-threatening medical conditions. If you are ill or injured outside of the operating hours of your physician's office or are outside of your local area when such illness or injury occurs, and you require immediate attention, you can use an urgent care center to receive treatment. The charges for physician services and applicable facility charges at an urgent care center will be paid by the Plan. A copayment will apply to such services. Out-of-Network Urgent Care centers are not covered.

### 11. Retail Health Clinics

Retail Health Clinics can provide you with care for non-life-threatening or non-emergency health issues. These clinics do not require appointments and are frequently housed within a retail location, such as a store or a pharmacy. The Plan will cover the appropriate charges when you visit an In-Network Retail Health Clinic. A copayment will apply to such services. Out-of-Network Retail Health Clinics are not covered.

## **D. HOME HEALTH CARE COVERAGE**

You may need additional support when you are discharged from a hospital or SNF or when you have an illness or medical condition that has worsened. In those cases, the Plan will provide you with home health care subject to preapproval. Home health care services under the Plan are not meant to help you with your basic living activities, but rather provide assistance in doing needed therapy, taking the right prescription at the right times, and monitoring you for any signs of worsening or decreasing health.

Coverage for Medically Necessary services is provided by an approved and participating home health care program for skilled, part-time and intermittent care, including payment for necessary skilled nursing and home health care aides. Such services will be for less than eight hours per day and less than seven days per week. Each visit by a member of the home health care team, each approved outpatient visit to a Hospital or SNF when physical therapy, occupational therapy, or speech evaluation, and each home health aide visit is considered the equivalent of one home health care visit.

Your home health care benefits coordinate with your hospital benefits, which means you may receive three home health care visits for every remaining unused inpatient day of the inpatient Hospital benefit period. The maximum number of visits under the home health care benefit is 1,095 (which is 365 Hospital care days times three). A new 1,095-visit period begins when you have not been in the Hospital, a SNF, or any other facility or received a service which is considered an "inpatient stay" for 60 consecutive days.

For example, if you receive home health care after spending 100 days in the Hospital, you can receive home health care benefits for up to 795 visits (365 days – 100 days = 265 days x 3 = 795 home health care visits).

## E. HOSPICE COVERAGE

Hospice is care designed to give supportive care to people in the final phase of a terminal illness and focuses on comfort and quality of life, rather than cure. Although hospice care does not aim to cure the terminal illness, it may treat potentially curable conditions such as pneumonia and bladder infections. Hospice care for terminally ill individuals when provided through an approved Hospice program is covered. This coverage will include care that will help manage any pain or discomfort you feel from the terminal illness, as well as treating any other illnesses or conditions that would normally be covered under the Plan.

The terminally ill individual (generally those with less than 6 months to live) must have written certification from a physician that he or she is terminally ill and meets the criteria for life expectancy. The individual must file an election statement with the Hospice program agreeing to the terms of Hospice care. Benefits for Hospice care are limited to 210 days per lifetime.

**Hospice care provides relief from the pain and symptoms of terminal illness**

## F. SURGICAL AND MEDICAL COVERAGE

You have coverage for a range of surgical and medical services, including, but not limited to:

- Surgery and anesthesia, including pre- and post-operative care (plastic and reconstructive surgeries are subject to limitations and/or exclusions);
- In-Hospital consultations;
- In-Hospital medical care;
- Necessary and appropriate diagnostic imaging, laboratory, and pathology services;
- MRI, MRA, CT, PET, and similar services are part of diagnostic imaging and may be limited to certain diagnoses, use of Carrier-approved facilities, or preapproval;
- Payment for digital mammograms and 3D mammograms is limited to the Allowed Amount for standard mammograms;
- Radiation therapy and chemotherapy for certain types of malignant conditions (e.g., cancer) (may require preapproval, depending on the particular therapy and condition);
- Immunizations and vaccinations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;
- Behavioral-based smoking cessation program, if preapproved by the Carrier;
- Pulmonary rehabilitation and Phase I and Phase II of cardiac rehabilitation; and
- Diabetes education.

See your Schedule of Benefits, Benefit Highlights Letters, and materials from your Carrier for details and limitations to the above-listed coverages.

## Second Surgical Opinion Benefits

The Plan will pay for you to have a second and/or third surgical opinion prior to proceeding with surgery for Medically Necessary care. You must receive physician services from an In-Network physician and arrange your second and/or third opinion with the Carrier.

If you receive a second opinion, all services are covered in full, including the physician's consultation and any necessary X-ray, laboratory services, and other tests. If the physician providing the second opinion disagrees with the recommendations of the first physician, you may obtain a third opinion from an In-Network physician.

## **G. AMBULANCE SERVICES**

If an ambulance is Medically Necessary, the Plan covers ambulance transportation to the closest available facility qualified to treat you as described below. Please note, if the ambulance company is not an In-Network Provider, you may be billed the balance between the Plan's Allowed Amount and the total amount of the bill.

### 1. Ground Ambulance

- Transfers between nearby Hospitals, because the originating Hospital lacks necessary treatment facilities, equipment, or staff;
- One way or round-trip transfer for a Hospital inpatient who must be taken to a non-Hospital facility for a covered diagnostic examination (provided the facility is a Participating Facility), when the services are not available in the Hospital to which the patient is admitted or in a closer local In-Network Hospital;
- Round-trip transfer of a homebound enrollee from home to the nearest available facility qualified to treat the enrollee when other means of transportation cannot be used without endangering the enrollee's life; and
- Emergency transportation for transporting an enrollee one-way from home or scene of an incident in cases of Medical Emergency or Accidental Injury to the nearest available facility qualified to treat the patient.

### 2. Air and Boat Ambulance

If air or boat ambulance is required, coverage may be subject to restrictions including mileage limitations and Coinsurance. Non-emergency air ambulance transport must be preapproved by the Plan through the Carrier before such transport will be covered. That preapproval will evaluate whether the transport is medically necessary and whether it is to the nearest location that can treat you. If possible, you should use an In-Network Air Ambulance Provider for any non-emergency transport. If using an Out-of-Network Air Ambulance Provider, the Plan will make efforts to reach an agreement with the provider so that no remaining balance is left for you to cover. In any case, the Plan will pay the lesser of 140% of the Allowed Amount or 70% of the Out-of-Network Provider's billed charges. If it is determined that transport by ground ambulance would have sufficed, payment will be limited to the amount that would have been paid for a ground ambulance.

## H. OUTPATIENT PHYSICAL THERAPY, OUTPATIENT FUNCTIONAL OCCUPATIONAL THERAPY, AND/OR SPEECH THERAPY

You have coverage for outpatient physical therapy, outpatient functional occupational therapy, and speech therapy if ordered by your doctor. Before receiving outpatient physical, functional occupational, or speech therapy, contact your Carrier to determine if the services will be covered for the condition, and if the outpatient Provider is an In-Network Provider. Functional physical, occupational, or speech therapy benefits will NOT be paid if received from an Out-of-Network Provider.

Up to 60 combined visits (per qualifying condition) per calendar year are covered for outpatient physical, functional occupational, and/or speech therapy provided by an In-Network Provider at an In-Network Facility. The 60-visit annual limit (per qualifying condition) may be renewed after surgery or a recurrence of the condition.

- Multiple therapy treatments occurring on the same day (whether physical, functional occupational, or speech) are considered a single visit.
- Speech therapy is covered when related to the treatment of an organic medical condition or to the immediate post-operative or convalescent state of the patient's illness. It is NOT covered for long-standing chronic conditions or inherited speech abnormalities (an exception is for children needing speech therapy under six years of age who have congenital and severe developmental speech disorders).
- Coverage for physical therapy is limited to when you have an expectation of improvement in a reasonable and predictable period of time.

Coverage for physical therapy and occupational therapy is not provided for the treatment of congenital conditions. Speech therapy is not covered for educational learning disabilities, deviant swallow or tongue thrust, or mild developmental speech or language disorders.

## I. MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE

You have coverage for mental health and substance abuse services. The Plan may require that you receive preapproval before receiving mental health or substance abuse services.

You must use an In-Network Provider for inpatient mental health and substance abuse services (except in cases of emergencies).

The Plan provides benefits for the following Medically Necessary mental health/substance abuse services:

- Up to a maximum of 45 days mental health inpatient care within a benefit period at a Hospital or Residential Treatment Facility;
- Up to a maximum of 45 days substance abuse inpatient care within a benefit period at a Hospital or Residential Treatment Facility;

- Up to a maximum of 35 mental health visits per benefit period;
- Up to a maximum of 35 substance abuse visits per benefit period;
- Up to 90 days/nights of medically necessary care in an In-Network mental health and/or substance abuse Partial Hospitalization Treatment Facility.

Substance abuse services such as dispensing methadone, testing urine specimens, physical exams, or other diagnostic procedures are covered. However, professional services are only covered if they are provided on the same day as those substance abuse services.

Family counseling services are only available for enrollees under the Plan and delivered by the same Provider who is performing services for the individual family member under treatment. Testing for vocational guidance, training, or counseling is not covered.

## **J. DENTAL COVERAGE**

Quality dental coverage is important to maintaining your overall health. The Plan covers, among others, the following dental services:

- Dental exams
- Dental cleanings, routine or periodontal twice per year
- Emergency dental services
- X-Rays
- Fillings, non-white or metallic
- Extractions
- Orthodontic services, if treatment begins before age 19

Certain limitations and exclusions apply to the dental coverage from the Plan. You should contact the Dental Carrier for a full list of this exclusions and limitations.

The Dental Coverage offered by the Plan has two levels of In-Network Provider. By going to a PPO Dentist, you will have the lowest cost-sharing. A summary of the benefits and applicable cost-sharing is available in the attached Schedule of Benefits.

## **K. VISION COVERAGE**

The Plan will cover, among others, the following certain vision services and devices:

- Annual routine vision exam
- Re-examination by an Ophthalmologist within 60 days of an initial examination when medically necessary
- Standard lenses
- Standard frames
- Contact lens evaluation, fitting, and follow-up care

A summary of the benefits and applicable cost-sharing for In-Network Providers is provided in the attached Schedule of Benefits.

## L. HEARING AID BENEFIT

The Plan covers hearing evaluations and hearing aids to cover deficits in hearing subject to certain limitations. Hearing aids must be one of those from an approved list maintained by the Plan. To receive a hearing evaluation and a hearing aid, you should contact the Hearing Administrator using the contact information at the back of this book. The Hearing Administrator will guide you through the selection of an appropriate provider and receiving all the necessary approvals to get your hearing aids. Your out-of-pocket costs will differ depending on the particular hearing aid selected, with more sophisticated hearing aids costing you more.

A summary of the out-of-pocket costs associated with the Hearing Aid Benefit is available in the attached Schedule of Benefits.

## M. COVERAGE OF SERVICES DELIVERED OUTSIDE OF THE U.S.

The Plan will pay for services rendered outside of the U.S. only in these limited circumstances:

- When you need emergency or urgent care;
- When you live in the U.S. and the hospital outside of the U.S. is closer to your home than the nearest U.S. hospital that can treat your medical condition; or
- When you are on a ship in the territorial waters adjoining the U.S.

## N. COVERAGE EXCLUSIONS

Medical services, supplies, and other health care expenses **not covered** include:

- Services, including inpatient Hospital days, provided prior to the effective date of coverage or after the termination of coverage;
- Services that are not Medically Necessary;
- Care, services, treatment, supplies, devices, and drugs that are Experimental and/or Investigational in nature;
- Services not ordered by a physician, provider, or other health care professional;
- Hospital services (including both facility and professional charges) not covered include:
  - Custodial, Domiciliary, convalescent, nursing home, or rest care;
  - Services consisting principally of dental treatment or extraction of teeth;
  - Admissions principally for physical therapy, tests or studies, or environmental control;
  - Hospital admissions and treatment for weight reduction or diet control (except for qualifying gastric bypass surgery); or



- Surgery for cosmetic purposes, except for the correction of congenital abnormalities, traumatic scars and conditions resulting from accidental injuries, as well as breast reconstruction in connection with a mastectomy;
- Skilled Nursing Facility stays not covered include:
  - Stays principally for Custodial or Domiciliary care; or
  - Stays for the care of tuberculosis;
- Facility charges for surgical services provided at Out-of-Network Ambulatory Surgery Centers;
- Physicians' services related to dialysis treatments in the home;
- Coverage is not available for services for treatment of mental disorders once they are determined that they are not amenable to modification;
- Coverage does not include diversional or recreation therapy (e.g., an organized program of leisure-based activity programs), which, in addition, may include activities that improve or sustain an individual's skills of self-care and daily living;
- Sterilization reversals;
- Artificial insemination or in vitro fertilization ;
- Allergy testing and treatment;
- Refractive keratoplasty (radial keratotomy) or similar vision-related procedures;
- Treatment of jaw joint or jaw hinge problems, including temporomandibular joint syndrome and craniomandibular disorders;
- Chiropractic services except for diagnostic radiological services and emergency first aid related to the spine and related bones and tissues;
- Physicals for pre-marital, pre-employment, or similar examinations or tests not directly related to diagnosis of illness or injury;
- Services covered in any way by federal or state programs, except as the Plan describes above with the Plan as secondary payor or when federal law requires the Plan to cover you as primary; and
- Expenses incurred for injuries resulting from or sustained as a result of commission, or attempted commission by the covered individual, of a felony. If the injury or illness is the result of domestic violence, or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor, then the exclusion may not apply.

## VII. NON-MEDICARE PLAN BENEFITS

This section explains your medical coverage when you are not eligible for Medicare but are enrolled in the Enhanced Care PPO (ECP) option. If you are in the ECP option, this section and Section VI for all enrollees will together inform you of your medical benefits. If you have an HMO, you should reference your Certificate of Coverage issued by the HMO for a description of these benefits.

### A. SKILLED NURSING FACILITY COVERAGE

The Plan will cover Medically Necessary Skilled Nursing Facility care under certain conditions for a limited time. A Skilled Nursing Facility (SNF) is a facility outside of the hospital that provides nursing care 24 hours a day under the supervision of a Physician and a registered nurse. A SNF can be used for rehabilitation and other skilled nursing services.

Coverage is provided for up to 100 days of care provided in an approved SNF per benefit period. If you do not use the allowed 100 days in the benefit period because you leave the SNF, you will use the remaining days from the 100 day allotment for SNF care if you re-enter the SNF if it is within 60 days of discharge from a SNF or Hospital. You are entitled to a new 100-day benefit period if you have not been in a SNF or Hospital for 60 consecutive days. You will also have coverage for another 100 day benefit period for SNF care at the beginning of each Plan Year. A doctor can see you up to two times per week while you are in the SNF.

**Skilled Nursing Facility Care is covered if preapproved and you have a favorable prognosis and a predictable level of recovery.**

The Plan will cover SNF care only if the following are true:

- You have days available in your 100 day benefit period and your stay is preapproved;
- The services are Medically Necessary for the treatment of your condition;
- The SNF must be a Facility that is Participating in the Plan (no coverage at Out-of-Network facilities);
- Your doctor has ordered the services you need for SNF care, which requires the skills of professional personnel, such as a registered nurse, licensed practical nurse, physical therapist, occupational therapist, or speech therapist, and are furnished by, or under the supervision of, these skilled professionals;
- You must be recovering from an injury or illness that has a favorable prognosis and predictable level of recovery;
- Care must fit within a treatment plan approved by the Carrier; and
- The intensity of care needed by the patient requires a combination of skilled nursing services on a daily basis that are less than those of a general acute care Hospital are but greater than those available in the patient's place of residence.

Benefits will not be provided for:

- Conditions that are not Medically Necessary or do not require skilled nursing services;
- Admissions that are principally Custodial in nature, for basic living assistance, or for treatment of tuberculosis;
- Adult foster care, assisted living, or Custodial Care (such as helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk, or take drugs or medications that can be self-administered);
- Patients who have reached their maximum level of recovery possible for their particular condition and no longer require treatment other than routine supportive care; or
- Services provided by Non-Participating or Out-of-Network SNFs.

## B. PREVENTIVE SERVICES

Preventive services are encouraged because by obtaining appropriate screenings, you may prevent health problems in the future. The Plan covers screenings that receive an A or B recommendation from the U.S. Preventive Services Task Force and select additional preventive services as described in the chart below. Preventive services are excluded from the Annual Deductible, Copayment, or Coinsurance requirements when received from In-Network Providers.

**Take advantage of covered preventive services. You may prevent future health problems by using these services.**

SERVICE	APPLICATION AND LIMITATIONS
PAP Smear	1 per year
Proctoscopic Exams Without Biopsy	1 every 3 years, for participants age 40 and older
Digital Rectal Exam	1 every 3 years, for participants age 40 and older
Mammogram	1 every year, for participants age 40 and older
PSA	1 every year, for participants age 40 and older
Fecal Occult Blood Test	1 every year, for participants age 50 and older
Fecal Immunochemical Test	1 every 3 years, for participants age 50 and older
Flexible Sigmoidoscopy, Barium Enema, Colonoscopy	For participants age 50 or older. 1 Flexible Sigmoidoscopy or 1 Barium Enema every 5 years OR 1 Colonoscopy every 10 years.
Hepatitis C Screening	For participants at risk, or who have signs or symptoms that may indicate Hepatitis C infection.
Immunizations and Vaccinations	Coverage is based on the recommendations and approvals of the Advisory Committee on Immunization Practices, including appropriate dosages, ages and frequency of administration (consult your Carrier for current provisions).

Preventive services may have gender, age, or frequency limitations, such as Prostate-Specific Antigen tests being available only to men between certain ages. Please contact your Carrier for more information. If the number of preventive services covered in a time period is limited, such as one per year, the first such service will be considered the preventive one and exempt from cost sharing. Any additional services within the time period, additional diagnostic services, services provided outside the related age windows and services provided by Out-of-Network Providers will be subject to any applicable cost-sharing features (such as the Annual Deductible, Copayment, or Coinsurance requirements) and normal Plan provisions.

## **C. PHYSICIAN OFFICE VISITS**

The Plan covers physician office visits for non-Medicare Enrollees and Dependents enrolled in the ECP plan. In order to take advantage of this benefit you must obtain treatment from an In-Network Provider. You will be encouraged to have a Primary Care Physician (PCP). The office visits to that PCP will include at least one annual wellness visit, as well as unlimited additional office visits. Covered Providers include In-Network Family Practice, General Medicine, Internal Medicine, Geriatrician, OB/GYN, Pediatrician, Nurse Practitioner, and Physician Assistant.

The Plan covers In-Network Specialist physician visits as well. These visits are also unlimited. However, your cost-sharing will be higher per visit than with visits to your PCP. These visits can also be with a nurse practitioner or physician's assistant working with your Specialist physician.

This benefit also includes your ability to get a second opinion. You should contact the Carrier to help you arrange such an office visit.

## **D. CASE MANAGEMENT**

You may be invited to participate in Case Management. In some instances, you may be required to participate in mandatory Case Management. The Plan, working through your Carrier, may require case management participation for certain conditions that are complex, severe, or rare. If a member refuses to participate in mandatory Case Management, the Plan will not pay for medical services, treatments, situations, prescription drugs, or other services related to the condition.

## **E. MANDATORY SECOND MEDICAL OPINION**

In some instances, you may be required by the Plan to seek a second medical opinion to review or confirm a diagnosis or treatment plan. The Plan will cover the costs of services connected with the second opinion, such as for X-rays or blood tests. The Plan will offer you a choice between two different providers from which to get the second opinion. If you refuse to have a second opinion, the Plan may discontinue coverage of services connected to that diagnosis or treatment plan, as well as other services.

## F. HUMAN ORGAN TRANSPLANTS

Human Organ Transplants are covered subject to certain requirements. All transplants must be preapproved by the Plan ahead of the transplant. All transplants must be performed at a Carrier-approved Center of Excellence (e.g., Blue Distinction Centers for Blue Cross Blue Shield).

Enrollment in Case Management is mandatory for all transplants except cornea, skin, or kidney (unless the kidney is transplanted alongside other organs, such as a pancreas). If you do not participate in Case Management, all transplant medical services, treatments, situations, prescription drugs, or other services related to the transplant will not be covered. Your enrollment in Case Management will begin before the transplant surgery is conducted and will continue after the surgery, in order to provide you with the best chance of a successful transplantation.

Contact your Carrier for information on appropriate transplant centers and details on which costs are covered.

## G. DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC (P&O) APPLIANCES

You have coverage for Medically Necessary durable medical equipment (DME) and prosthetic and orthotic (P&O) appliances prescribed by your doctor. You or your physician may contact your Carrier for preapproval, claims processing, locating Network Providers, and for any other questions or concerns.

### 1. In-Network DME and P&O Suppliers

DME and P&O appliances must be obtained from an In-Network Provider or Supplier. You may identify In-Network Providers or Suppliers by contacting your Carrier. If an Out-of-Network DME Provider is used, then no benefits will be paid. DME and P&O appliances must be medically necessary and covered by the Plan.

### 2. DME Coverage

Durable medical equipment (DME) coverage includes, but is not limited to:

- Equipment that meets Plan standards and is appropriate for use in the home and must generally include being approved under Medicare Part B;
- Repairs necessary to restore the equipment to a serviceable condition as when the equipment was purchased (this does not include routine maintenance);

**You must use an In-Network DME Provider to receive DME coverage. Diabetic test strips and lancets are covered under the DME benefit. Insulin is covered under the prescription drug benefit.**

- Equipment that is used in a hospital or skilled nursing facility, or when used outside of the hospital or skilled nursing facility and rented or purchased from the such hospital or facility at discharge;
- Special features necessary to adapt otherwise covered equipment for use by children;
- Equipment must appear on a list maintained by the Carrier.

Prosthetic and orthotic (P&O) appliance coverage includes, but is not limited to:

- P&O appliances that are furnished by an In-Network facility and meet Plan standards (which includes being approved for reimbursement under Medicare Part B), including the replacement, repair, fitting, and adjustments of the appliance;
- Therapeutic and orthopedic shoes, inserts, arch supports, and shoe modifications when the shoes are part of a covered brace (unless you meet other criteria of the Carrier, such as being diabetic, and then your shoe modifications do not need to be part of a brace);
- Hair pieces/wigs (when suffering hair loss from chemotherapy, radiation, or other treatments for cancer);
- Prescription lenses following a cataract operation or an operation to replace a missing lens because of a congenital condition; and
- Appliances or devices that are surgically implanted permanently within the body (except for Experimental or research appliances or devices) or those that are used externally while in the Hospital as part of regular Hospital equipment or when prescribed by a physician for use outside the Hospital.

Certain exclusions apply to the Plan's coverage of DME and P&O appliances including, but not limited to:

- Deluxe versions of equipment that are not medically necessary;
- Items not medical in nature;
- Physician's equipment (such as stethoscopes);
- Exercise equipment;
- Hygienic equipment (such as bidets, toilets seats);
- Equipment that has been determined to be Experimental;
- Pulse oximeters; and
- Supplies for wound care



## H. NON-MEDICARE PRESCRIPTION DRUG PLAN IN THE ECP

### 1. Prescription Drug Covered Expenses

You have prescription drug coverage. Covered prescription drugs include drugs approved by the Food and Drug Administration (FDA) and that are required to be labeled, “Caution – Federal Law prohibits dispensing without a prescription” and insulin. This includes those drugs called “biologics” and “biosimilars,” both of which are created in a slightly different fashion than traditional prescription drugs. The Plan does not cover “over-the-counter” medications.

### 2. How Prescription Drug Coverage Works

Your prescription drug coverage has both a retail pharmacy component and a mail order component and is administered by a Pharmacy Benefit Manager (PBM). Benefits are provided for the payment of the prescription charge, less the applicable Copayment for each separate prescription order or refill.

### 3. Prescription Drug Copayments

When you have a prescription drug filled, you will typically pay a Copayment. If the cost of the drug is less than your Copayment, you will only pay the cost of the drug. Your prescription drug Copayment amount for each prescription order or refill will be determined based on whether the drug is generic or brand name, the applicable “tier” (or level) of the drug, and how the drug is dispensed. The Plan establishes these Copayments annually and publishes them in the Benefit Highlights Letter.

**For greater cost-savings, always request that your doctor prescribe a generic drug.**

### 4. Generic and Brand-Name Medications

Prescription drugs are dispensed under two names: the generic name and the brand name. A generic drug is chemically equivalent to a brand drug for which the patent has expired. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. Generic and brand medications are further divided by the Plan into generic, preferred brand, and non-preferred brand.

When you receive a brand name medication, especially a non-preferred brand name drug, you generally pay more. Your Physician or pharmacist can assist you in substituting generic medications when appropriate. Generic drugs have the lowest Copayment. For greater cost-savings, always request that your doctor prescribe a generic drug.

If your doctor has not indicated “Dispense As Written” or DAW, your prescription automatically will be filled with a generic drug (when available). If you still want the brand-name drug, you will pay a higher copay.

Similar to the situation with brand and generic drugs are biologic drugs and biosimilars. Biologic drugs are special kinds of medications developed using living organisms to produce the active substance. Biosimilars are like generic drugs but for biologics. Biosimilars may not be able to be automatically substituted when you get a prescription for a biologic filled, so you should speak to your doctor about the availability of a lower-cost biosimilar instead.

With certain classes of drugs, the Plan will only cover those drugs in that class that are generics. The formulary will list which classes and drugs where this is the case.

### 5. Maintenance Drug List (MDL)

Maintenance drugs are certain drugs taken on an ongoing basis (three months or more), such as those used to treat high blood pressure or high cholesterol. The Plan has established a list of maintenance drugs that are only covered for non-Medicare members when filled by mail order after limited initial dispensing. This list is subject to change periodically.

**Some of the most commonly prescribed drugs on the MDL are for:**

- Blood Pressure Control**
- High Cholesterol**
- Diabetes**
- Thyroid Issues**

MDL prescriptions filled at a participating retail pharmacy will be limited to a 30-day supply. The Plan will cover only the first three prescription drug fills at your retail pharmacy (the initial fill and two refills).

The Plan will cover 90-day supplies of the drugs you are prescribed on the MDL through Plan-specified pharmacies. On the fourth fill, you must have your MDL prescription filled by Plan-specified pharmacies or pay the full cost of the drug at retail. If you begin taking a prescription drug on the MDL, the PBM will notify you about using specific pharmacies.

Special rules may apply if you reside in a long-term care or assisted living facility. Contact the PBM if you have any questions about the MDL.

### 6. Retail Pharmacy

For short-term prescription needs, you can receive up to a 30-day supply of your covered medication for one retail Copayment. Filling your prescriptions at retail is most appropriate for your short-term prescription needs. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in the network. A retail pharmacy is also appropriate for situations in which your physician has not established the suitable drugs, strengths, and dosages for ongoing needs.

### a. Participating Retail Pharmacies

The Plan contracts through the PBM to provide a national network of participating retail pharmacies. When you purchase covered prescription drugs from a participating retail pharmacy, simply present your prescription order and your ID card to the pharmacy and pay your retail Copayment. You do not have to submit any paper claims to the PBM when you use a participating retail pharmacy.

To find out whether a pharmacy participates in the network call the PBM at the number listed on the back of your pharmacy benefit ID card.

### b. Non-Participating Retail Pharmacies

When you purchase covered prescription drugs from a Non-Participating retail pharmacy, you must pay the full price (100%) of the prescription and obtain a prescription receipt that you can submit to the PBM for reimbursement. You will be reimbursed 75% of the Plan's price of the drug after deducting the applicable Copayment. You will be responsible for the difference in cost between the amount charged and the Plan's price, plus 25% of the Plan's price after deducting your retail Copayment.

Example: Lynn fills a covered medication at a Non-Participating pharmacy. She was not away from home without access to a Participating pharmacy, such as on vacation, nor was it an emergency. The pharmacy charges Lynn \$550 for her drugs. She submits the receipt to the PBM for reimbursement. The drug was a generic drug, so her Copayment is \$5. The Plan's price for the drug is \$500. The PBM will send Lynn \$370 total (Plan's price \$500 X .75 = \$375. \$375 – \$5 Copayment = \$370.) Lynn will have paid \$180 for her drugs. If Lynn had received the drug from a participating pharmacy, she would have only paid \$5.

If prescription drugs must be purchased from a Non-Participating pharmacy because you are away from home without access to a Participating pharmacy or due to an emergency, you will still be required to pay the full charge and file the claim for reimbursement. However, you will be reimbursed 100% of the Plan's price minus your applicable Copayment.

Claim forms to submit claims for prescription drugs purchased at a Non-Participating retail pharmacy are available through the PBM and must be submitted within one year of the date the drug was dispensed to be eligible for coverage.

### 7. Mail Order Pharmacy

Mail order allows you to purchase up to a 90-day supply of your maintenance prescription drugs. All mail order prescriptions are mailed directly to your home.

To start using mail order, complete the PBM's prescription order form and mail it to the PBM along with your doctor's original prescription and the applicable Copayment. You can expect to receive your first filled prescription about two weeks from the time you mail your prescription. If you need a medication right away, make sure your physician provides you with two prescriptions: one prescription for a 30-day supply for use at a participating retail pharmacy, and a second prescription for a 90-day supply to be sent to the mail order pharmacy. Refills can be ordered using the PBM's website, calling the PBM, or by mailing in the refill order slip.

To find the contact information for your mail order pharmacy, refer to the Contact Information at the end of this SPD.

### 8. Quality and Utilization Management

To promote safety and clinically appropriate care while controlling costs, prescription drug coverage may be restricted in quantity or require prior authorization and/or step therapy.

#### a. Quantity Restrictions –

For certain drugs, the amount of the drug that will be covered by the plan is limited based on national standards and current literature. These limits ensure the quantity of units supplied for each prescription remain consistent with clinical dosing and safety guidelines, including building up a required tolerance for a drug, and benefit plan design.

#### b. Prior Authorization –

The Plan requires a review with a physician to determine if the drug qualifies for coverage under the benefit. If your physician prescribes a drug that requires a prior authorization, the PBM will contact your physician to complete the prior authorization review.

#### c. Step Therapy –

In some cases, you are required to first try certain drugs to treat your medical condition before the Plan will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Plan may not cover Drug B unless you try Drug A first.

### 9. Prescription Drug Expense Exclusions

Prescription drug services, supplies, and medications not covered under the Plan include:

- Drugs not approved by the FDA, including off-label use (meaning drugs that may be prescribed, but are not approved for that condition or age group) (an exception to this restriction is for medically necessary treatment of gender dysphoria);
- Drugs available without a prescription or “over-the-counter” drugs;

- Drugs labeled “Caution: Limited by federal law to investigational use”;
- Any drug being used for cosmetic purposes, even if it contains a Federal Legend Drug (treatment of gender dysphoria shall not be considered a cosmetic purpose);
- Medical devices or appliances;
- Prescription drugs not covered by a current prescription order;
- Drugs not on the Plan’s Formulary;
- Diabetic supplies covered under Medicare Part B or your Carrier’s Durable Medical Equipment (DME) Program (e.g., home blood glucose monitor, test strips);
- Drugs used for treatment of erectile dysfunction or inadequacy;
- Drugs in the Proton Pump Inhibitor (PPI) class of drugs used to treat conditions such as heartburn, acid reflux (GERD), and ulcers;
- The charge for any medication for which the individual is entitled to benefits without charge from municipal, state, or federal programs; and
- Any compounded drugs that contain products excluded by the Plan.

## VIII. NON-MEDICARE PLAN RULES

NOTE: If you have a claim or appeal involving an HMO option, you should consult that Carrier's booklet for the proper procedures for resolving claims and appeals or coordination of benefits. You must obtain services under the terms of your HMO in order for the services to be covered.

### A. COORDINATION OF BENEFITS

When you or your Dependents have coverage under more than one plan, there may be duplication of coverage – two plans in a position to pay for benefits for the same expenses. For example, you may be covered by the Plan and by a Spouse's coverage from his or her current employer. When this situation happens, the Plan coordinates the benefits of the two (or more) plans that cover you or your Dependents. Coordination of Benefits (COB) ensures that you and your Provider are not paid twice for the same benefit.

The Coordination of Benefits rules determine who will pay health care claims as primary when you or a family member are covered by more than one plan. The primary plan processes claims first. After the primary plan has paid, the secondary plan would review any remaining balance to see if additional benefits are payable. All covered charges under the Plan are subject to Coordination of Benefits.

NOTE: Coordination of Benefits when you or a Dependent has Medicare is discussed in the earlier section about Medicare coordination with the TCN plan. This section focuses on coordination when You or a Dependent have two non-Medicare plans.

The Plan may pay a secondary balance for covered services up to the amount the Plan would have paid if it were the only coverage. If the Plan would not cover the service when it is the only plan paying, it will not cover the service when it pays secondary.

If you or your Dependents are enrolled in two Trust-sponsored Plans, the two Plans will not coordinate. You will only receive the benefits of one Trust Plan. For example, Mary is the widow of John, who worked for and retired from GM and Chrysler. When Mary is admitted to the hospital, she will still be paying her coinsurance following her deductible. The Trust-sponsored Plan for the GM retirees will not cover the unpaid portion of the Trust-sponsored Plan for Chrysler retirees.

#### 1. *Order of Benefit Payment*

When a health care claim is reviewed for reimbursement, covered charges are coordinated as follows:

- The primary health plan pays benefits first, without regard to any other health plan.

**The Plan will coordinate your benefits with other plans. You will not get the same benefit twice, nor will your Provider be paid twice because you have two plans (even if both these plans are Trust plans).**



- When the Plan is the secondary plan, covered charges are processed so that the total benefits paid will not be greater than the Plan's Allowed Amount.
- If you fail to follow the procedures of the primary plan and are denied coverage of a service because of that, the Plan will not pay secondary or primary for that claim.
- If the primary plan denies your coverage because it is not a covered benefit under that plan, the Plan may pay secondary if it is a covered benefit under this Plan.

A health plan without a coordination of benefits rule is always the primary plan. If all plans have a coordination rule, covered charges will be coordinated as follows:

- The health plan covering you or your Dependents as an active employee or non-Medicare retiree, rather than as a dependent, is primary. If you or your Dependents are covered in the same status by more than one plan (e.g., active and active, retiree and retiree, etc.), the plan that covered him/her the longest is primary.
- If you are retired or disabled and covered under Medicare, and you are also covered as a dependent of a spouse who is an active employee, the active employee's health plan is primary.
- If a Dependent child is covered by more than one health plan, the plan of the employee or Primary Enrollee whose birthday occurs first in the calendar year is primary. If the birthdays are the same day, the plan that has covered the dependent longer is primary.

If you are separated, divorced, or never been married, dependent children are covered as follows:

- If a court order places the responsibility for the child's health care on one of the parents, that parent's plan is primary.
- When no court decree designates financial responsibility, the plan of the parent with physical custody is primary, followed in order by the plan of the spouse (or same-sex domestic partner) of the custodial parent, the plan of the non-custodial parent, and the plan of the spouse (or same-sex domestic partner) of the non-custodial parent.
- If the parents share joint physical and financial responsibility, the plan of the parent whose birthday occurs first in the year is primary.

If a person whose coverage is provided under a right of continuation provided by federal or state law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee or retiree, or their dependent, is primary and the continuation coverage is secondary.

If the preceding rules do not determine the primary plan, the plan that covered the person longer is primary. If a determination cannot be made using these rules, the allowable expenses shall be shared equally between the plans.

If you are covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

Contact your Carrier if you have questions about which plan is primary or how Medicare eligibility affects payment.

## EXAMPLE: TWO HEALTH PLANS



**George:**  
Non-Medicare/Trust  
retiree (policyholder)



**Mary:**  
Non-Medicare/ABC  
retiree (policyholder)

George and Mary are married and each a dependent spouse on the other's coverage



**George:**  
Trust retiree  
(policyholder)



**Mary:**  
Actively employed  
at ABC Co.

George and Mary are married and each a dependent spouse on the other's coverage



Here's an example of how the coordination of benefits calculation works when there are two health plans involved:

- Mary is the spouse of a UAW retiree named George. Mary is a non-Medicare retiree who has her own medical coverage through ABC Health. Mary is also listed as a dependent under George's plan through the UAW Retiree Medical Benefits Trust (Trust).
- When Mary has services provided, her retiree health plan (ABC Health) is the primary plan and George's Trust plan is the secondary plan.

The allowed amounts and deductibles are for illustrative purposes only. Note: Each health plan maintains its own payment schedule. Therefore, allowed amounts can vary between health plans.

Mary receives a service that both ABC Health and the Trust would cover. If Mary only had her ABC Health plan, she would be responsible for \$880, but with the Trust paying secondary, Mary will pay \$640 for that service.

## HERE ARE THE CALCULATIONS FOR MARY:

First, here is what Mary's health plan, ABC Health, would pay if that were the only coverage she had:

<b>Allowed amount under Mary's plan - ABC Health</b>	<b>\$2800</b>
<b>Less Deductible required under Mary's Plan - ABC Health [paid by Mary]</b>	<b>-400</b>
<b>Balance</b>	<b>2400</b>
<b>Less 20% ABC Health Coinsurance [paid by Mary]</b>	<b>480</b>
<b>Payment made under Mary's plan - ABC Health</b>	<b>1920</b>
<b>Mary's liability</b>	<b>\$880</b>

Second, the plan for Mary's husband George, the Trust, will cover some of her remaining cost. The Trust, when paying secondary will still need to make sure its deductible and any coinsurance are met.

The calculation begins with the Allowed Amount of whichever plan is lower.

<b>Allowed amount under Mary's Plan - ABC Health</b>	<b>\$2800</b>
<b>Less Deductible required under George's Plan - Trust</b>	<b>-400</b>
<b>Balance</b>	<b>2400</b>
<b>Less 10% in-network Trust Coinsurance</b>	<b>-240</b>
<b>Balance</b>	<b>2160</b>
<b>Less amount paid under Mary's Plan - ABC Health</b>	<b>-1920</b>
<b>Trust secondary payment amount</b>	<b>\$240</b>
<b>Mary's total payment (remaining unpaid amount)</b>	<b>\$640</b>

### 2. Coordination with Other Insurance Policies

The Plan will coordinate coverage with other insurance policies, including group or individual automobile, homeowner's or premises insurance, personal injury protection, workers' compensation insurance, or no-fault coverage, including medical payments. Other insurance policies will be primary. The Plan will not pay more than the Plan's Allowed Amount. Deductibles and copayments will be included in coordination of benefit calculation.

## B. CLAIMS PROCESS

For this section, George will be used as an example. George is a Plan enrollee in ECP with high blood pressure and high cholesterol. Lynn is George's Spouse and is also enrolled in the Plan as a Spouse.

### 1. What is a "Claim"?

A Claim is a request for benefit or service to be covered by the Plan.

George visits his doctor. The doctor files the claim with the Plan on George's behalf.

### 2. How to File a Claim

You should present your health care identification card whenever you go to a Hospital, outpatient treatment facility, physician, or other health care Provider of covered services anywhere in the country. If you go to a Pharmacy, you should also show your prescription drug identification card. Most Providers, including all In-Network Providers, will bill the Carrier and be paid directly by the Carrier. Contact information for your Carrier, including addresses, is included on your ID card, as well as at the end of this SPD.

When the Provider does not file a claim for you, you should submit the charges directly to the Carrier at the address that is on your identification card. Any payment you receive for that service, if you have not already paid the Provider and are seeking reimbursement from the Plan, should be immediately forwarded on to the Provider. If your Provider does not bill the Carrier directly, you may wish to ask why he, she, or it does not.

With pharmacies, presenting your prescription drug identification card and asking for a fill of a prescription is not, technically, a claim. The claim occurs if you reach out (or have someone reach out on your behalf) to the PBM. Most of the time, the pharmacy will make that claim step on your behalf.

Example 1:

George visits his In-Network doctor. The person at the reception area makes a copy of his card. After George's visit with the doctor, the doctor has his office file the claim with the Plan. The doctor writes George a prescription for a new blood pressure medication to try. George goes to his local Participating pharmacy to get the prescription filled. The pharmacy fills George's drug. The pharmacy files the claim with the Plan.

Example 2:

George goes to get a prescription filled at his pharmacy. The drug is not on the Plan's formulary, but George decides he wants the drug. He pays for it out of pocket. George then files a claim with the Plan for reimbursement. If the Plan still denies the drug (which is likely because it is not on the Plan's formulary), George will have the option to appeal.

### 3. Deadline for Filing Claims

Claims are due no later than the end of the calendar year following the year of service. Claims received after this period will be denied unless you can show that it was not possible to provide such notice of claim within the required time and that the claim was filed as soon as was reasonably possible.

### 4. Notice of Claim Decision

The Carrier will give you notice of the decision on a claim. Usually, this will take the form of the Explanation of Benefits, which is mailed to your home and describes what was covered and what was not. When an item is not covered, the notice will refer to the specific provisions of the Plan on which the denial is based and explain whether any additional information is required from you. In the notice, the Carrier will identify the address to use to file an appeal if you disagree with the claim decision (appeals are covered in Sub-section C below). The Carrier will decide your claim within the deadline for the type of claim involved (i.e., urgent claim, pre-service claim, post-service claim, or concurrent care claim). These types of claims and the rules applicable to each are described below.

### 5. Types of Claims and Deadlines for Decisions

#### a. Urgent Claims

Special rules apply to claims requesting urgent medical care or a prescription drug fill. These rules require notification to you about your claim status within 72 hours after receipt of the request for review. Specifically, an urgent care claim is any claim for medical care or treatment or a prescription drug, which, if determined within the time periods for making determinations of pre-service claims:

1. Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or
2. Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Provider with knowledge of your condition.

Example:

One Saturday, George is watching a football game when he starts having intense chest pains. He takes an ambulance to the nearest ER. George's doctor decides he needs to have an angioplasty within the next 72 hours. The Hospital or his doctor will file an urgent care claim on George's behalf. Even though the service will usually be covered, if the service is denied, George will have an ability to file an urgent appeal as described in Sub-section C.

b. Pre-service Claims

A pre-service claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before you obtain medical care or receive a particular prescription drug. In this SPD, if you read that a benefit requires “preapproval,” that is one of the benefits where a pre-service claim is necessary. The Carrier or PBM will inform you of the decision on a pre-service claim within 15 days of receipt of your request.

Example:

Lynn injures her knee after tripping down the stairs. Her doctor would like Lynn to have arthroscopic surgery on that knee to see what the problem is. The surgeon would file a pre-service claim to make sure it is covered.

c. Post-service Claims

Post-service claims are any claims for health care benefits that are not pre-service claims. In the case of a post-service claim, as defined by applicable regulations, the Carrier will notify you of the benefit determination on review within a reasonable period of time, but not later than 30 days after receipt by the Carrier.

d. Concurrent Claims

A concurrent claim is a claim for benefits after the Plan has approved an ongoing course of treatment over a period of time (like days in the hospital) or number of treatments (10 physical therapy visits) and an extension of benefits is sought or the Plan terminates the treatment because you have improved. In the case of a concurrent claim, as defined by applicable regulations, the Carrier will notify you of the benefit determination as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated.

Example:

Lynn enters the hospital after her bad knee gives out on her completely. After a few days, she is able to stand and walk on her own. Lynn would like to stay in the hospital, so the Hospital files a claim for an extension of her stay. The Plan’s denial of that extension is a concurrent claim because Lynn had an approved ongoing course of treatment (days in the hospital) and sought an extension of that benefit (more days).

	<b>Urgent</b>	<b>Concurrent</b>	<b>Pre-service</b>	<b>Post-service</b>
<b>Plan must make Initial Claim Benefit Determination as soon as possible but no later than:</b>	<b>72 hours</b>	<b>Before the benefit is reduced or treatment terminated.</b>	<b>15 days</b>	<b>30 days</b>
<b>Extension permitted during initial benefit determination?</b>	<b>No</b>	<b>No</b>	<b>15 Days</b>	<b>15 days</b>



## C. APPEAL PROCEDURES

If a claim is denied in whole or in part, you have the right to file an appeal to have your claim reviewed. You must follow the procedures described in this section to file an appeal. The Plan follows the appeal procedures required by the applicable ERISA statute. Since parts of this Sub-section are complicated (and written to meet statutory requirements), an example with George follows these rules.

You will be given an opportunity for a full and fair review by the Plan Administrator, or its delegate, of a claim denial. A denial of a claim is called an “adverse determination.” If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, you will be provided either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination. A copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the adverse benefit determination is based on Medical Necessity or Experimental treatment or similar exclusion or limit, you will be provided either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The Plan has given authority to the Carrier to have discretionary authority to interpret and apply the Plan. The individual or individuals at the Carrier who made the initial benefit decision will not be the same persons who decide your appeal, nor will those initial decision-makers be the supervisors of those who will decide the appeal. The review will not give deference to the initial denial.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary or appropriate, the Carrier will:

- Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify the medical or vocational experts whose advice was obtained on behalf of the Carrier in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- Provide that the health care professional engaged for purposes of the consultation referenced above will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor a subordinate of any such individual.

After you receive notice that a claim was denied, in whole or in part, you have 180 days to make a written request to the applicable Carrier to have the claim reviewed. If a claim meets the definition for urgent care under applicable federal regulations, the request may be submitted by telephone. As part of the review, you may submit any written comments that may support the claim. A written decision on the request for review will be furnished to you as described in the chart.

You have two levels of appeal for medical claims and prescription drug claims.

- To initiate a level 1 review, you or your authorized representative must send the Carrier a written statement explaining why you disagree with their determination. A particular Carrier may not call the first appeal step “level 1,” but all Carriers include this step. Please include in your request all documentation, records, or comments you believe support your position. You must request review no later than 180 calendar days after you receive the claim decision. Mail your written request for review to the address in the letter the Carrier sent notifying you that they have not approved a benefit or service you are requesting. The Carrier will respond to your request for review in writing within 30 days, unless they have notified you in writing that they need additional information to complete their review. If you agree with their response, it becomes the final determination, and the review ends.
- If you disagree with the response to your level 1 appeal, you may then proceed to level 2. You must request a level 2 review in writing no later than 30 calendar days after you receive the level 1 determination for medical claims and 90 calendar days for prescription drug claims. Mail your request to the address specified in the letter the Carrier sent notifying you that they have not approved your level 1 appeal. Please provide all documentation, records, and comments that support your position. The Carrier will provide you a written determination within 30 days of receipt of your request for a level 2 review, unless they notify you in writing that additional information is needed for them to complete their review. The PBM will inform you of decisions in the second level of appeals on pre-service prescription drug claims within 15 days of receipt of your request.
- If you disagree with the final determination, or if the Carrier fails to issue its determination at each level within the 30-day timeframe or otherwise fails to comply with the review procedures for level 1 or level 2, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits. The second level appeals for non-urgent claims is considered final and binding. However, you can appeal through the Voluntary Appeal Process described below. If you do not wish to request a Voluntary Appeal, you have the right to file a civil action under ERISA.

### Medical Claims

	Urgent	Concurrent	Pre-service	Post-service
<b>Appeal request must be submitted to the Plan within:</b>	<b>180 Days</b>	<b>180 Days</b>	<b>180 Days</b>	<b>180 Days</b>
<b>Plan must make Initial Claim Benefit Determination as soon as possible but no later than:</b>	<b>72 hours</b>	<b>Before the benefit is reduced or treatment terminated.</b>	<b>30 days</b>	<b>30 days</b>
<b>Second Appeal Request must be submitted to the Plan within:</b>	<b>N/A</b>	<b>N/A</b>	<b>30 days from receipt of first level appeal determination</b>	<b>30 days from receipt of first level appeal determination</b>

## Prescription Drug Claims

	Urgent	Concurrent	Pre-service	Post-service
<b>Appeal request must be submitted to the Plan within:</b>	<b>180 Days</b>	<b>N/A</b>	<b>180 Days</b>	<b>180 Days</b>
<b>Plan must make Initial Claim Benefit Determination as soon as possible but no later than:</b>	<b>72 hours</b>	<b>N/A</b>	<b>15 days</b>	<b>30 days</b>
<b>Second Appeal Request must be submitted to the Plan within:</b>	<b>N/A</b>	<b>N/A</b>	<b>90 days</b>	<b>90 days</b>
<b>Plan must make a Second-Level appeal decision as soon as possible but no later than:</b>	<b>N/A</b>	<b>N/A</b>	<b>15 days</b>	<b>30 days</b>

### 6. Voluntary Appeal Process

If you disagree with the decision of the Carrier's final claim denial after appeal, at your option, you may file a voluntary appeal with the Plan. The Voluntary Appeal Process is provided to you so that the Plan can ensure consistent application of its rules. Between when your claim was first decided and when it is reviewed in a voluntary appeal, the Plan might consider changes in generally accepted medical standards (for example, a change in the approval of a particular prescription drug).

The Carrier's final determination completes the appeal process and you are not required to file a voluntary appeal. Certain adverse benefit determinations may not be sent to the Plan as a voluntary appeal, including:

- Adverse benefit determinations denying a service because it is experimental or investigational, and
- Benefits or services that are specifically excluded from coverage under the Plan Document or applicable Carrier's medical policy or guidelines.

Whether or not you submit your denied claim for voluntary appeal will not affect the other benefits under the Plan.

You can elect to submit a denial for review under the voluntary appeal procedure only after exhaustion of the appeal process described above. To request a voluntary appeal, submit: your name, name of plan, reference to the decision, copies of denials, and an explanation of why you are appealing the decision. This information should be submitted to:

The UAW Retiree Medical Benefits Trust  
 Attention: Appeals Coordinator  
 P.O. Box 14309  
 Detroit, MI 48214-0309

## 7. *Illustrative Example of Claims and Appeals Process*

George was shoveling his front steps after a recent snowfall when he slipped and fell down the steps on an unseen ice patch. George fell and hit his tailbone on one step and bounced onto the ground.

Lynn helps George inside. George lies in bed, but ignores Lynn's requests that he go to the ER about his tailbone. His pain in the tailbone does not get better, so George eventually relents and lets Lynn drive him to the ER. Lynn has to help him to the car, as George is now dizzy and off-balance.

At the ER, George reports to the doctors about his fall and his tailbone, but that he had waited for four days because he didn't think it was serious. The ER notes a possible broken tailbone as the primary diagnosis. George also continues to stumble as they have him walk to get his X-ray. The ER doctor, suspicious of this stumbling, orders a CT scan of George's head. The CT scan does not reveal any serious injury to George's brain.

The claim for George's ER visit is submitted to the Carrier with the primary diagnosis of a possible broken tailbone. Even though George might have a broken tailbone, George waited longer than 72 hours to go to the ER, making the tailbone injury no longer an emergency. The ER does not initially supply evidence of the reason for ordering the CT scan. Because the Carrier does not know that George was stumbling or that he may have hit his head, the Carrier denies the coverage of the CT scan as well as it also was past the 72 hours.

Given the stumbling that George was doing, George files an appeal with the Carrier.

The Carrier reviews his appeal. The people at the Carrier reviewing the case are different from those who reviewed the claim initially. The ER supplies the information about what George reported in the ER. However, not noted by the ER or the Carrier was that George was not stumbling initially, but only after the second day in bed. The Carrier denies the claim as still not meeting the 72-hour requirement for an ER visit.

The Carrier has again a different group of people review the claim and may seek an outside medical opinion. Upon the second level of appeal, the Carrier still sees no basis to overturn the ER visit denial, as no evidence had yet been presented on when George's possible head injury appeared.

At this stage, George has "exhausted" his appeals with the Carrier and now must decide whether he will (a) accept the Carrier's decision and find another way to pay for the ER visit, (b) disagree with the Carrier's decision, hire a lawyer, and file a lawsuit in his local U.S. District Court, or (c) file a Voluntary Appeal with the Plan.

George opts for option (c) and follows the instructions above to file a voluntary appeal with the Plan. The Plan reviews his case and discusses his, the ER's, and the Carrier's evidence. About a month later, the Plan writes to George to inform him that it has determined that his head injury presented later than his original injury, and thus met the emergency criteria under the Plan. The Plan has instructed the Carrier to pay for his claim.

## 8. Legal Proceedings

You may not bring any action in court to recover benefits before you have exhausted all of your remedies under the Plan's claims and appeals procedures. However, you are not required to follow the Voluntary Appeal Process prior to bringing an action in court. Any lawsuit against the Plan must be commenced within one year from the date of the last decision rendered by the Plan or its Carrier regarding the claim. If you submit a claim for voluntary appeal, that one-year time limit is put on hold while the review is ongoing. A new one-year limit will start following the voluntary appeal's completion.

## 9. Authorized Representatives

An authorized representative, such as your Spouse, adult Child, or other individual, may file a claim for you and represent you in any claim reviews if you are unable to do so yourself. Contact the Carrier for the form needed to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

## 10. Assignment of Benefits

You and your Dependents are the intended beneficiaries of this Plan. You may not assign benefits or legal rights under the Plan, unless specifically authorized by the Plan to do so or a Court orders you to do so. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan under any circumstances. When you see a doctor, get a test done, or fill a prescription, the Plan may pay (through the Carrier) those Providers and Suppliers directly, rather than send the money to you.

## 11. Improper or False Claims

If you furnish false information on any material subject to the Plan, or to any of its agents or employees, the Plan will deny all or part of your claim and will charge you for any expenses incurred relating to the false information. If benefits have already been paid, based on the false information on a material subject, the Plan will recover the benefits from you, plus expenses incurred in such recovery, including attorney's fees, costs, and any and all other expenses, and/or will reduce future benefits for your claims until the Plan has recovered the benefits paid.

The Committee may terminate coverage for any act or omission by a Retiree, Surviving Spouse, or Dependent that indicates intent to defraud the Plan, such as the intentional and/or repetitive misuse of the Plan's services or the omission or misrepresentation of a material fact on an application for enrollment, claim, or other document. Grounds for termination include the submission of any claim and/or statement containing any materially false information, any information that conceals for the purpose of misleading, and/or any act that could constitute a fraudulent insurance act.

# IX. INFORMATION FOR ALL ENROLLEES

## A. COBRA CONTINUATION COVERAGE

When you or a Dependent lose coverage, you may be eligible for “COBRA continuation coverage.” COBRA is a federal law that gives certain eligible participants the right to continue health care coverage at group rates for a set period of time. If a spouse or a covered family member should become ineligible for Plan coverage because of a “Qualifying Event” (described below), he or she may be able to continue coverage for up to 36 months. COBRA Continuation Coverage generally is the same health coverage the Dependents had the day before beginning COBRA Continuation Coverage.

A Same-Sex Domestic Partner who loses coverage under the Plan does not qualify for COBRA Continuation Coverage under the federal government’s COBRA regulations. However, the Plan allows the Same-Sex Domestic Partner to continue coverage in the same manner as a Spouse, as long as the opportunity is elected in a timely manner and the required Contributions are made; or if the Same-Sex Domestic Partner relationship ends, in the same manner as a divorced or legally separated Spouse by making self-payments (in the same amount as the COBRA payment) for coverage for up to 36 months.

### 1. *Qualifying Events*

For the spouse of a Retiree covered by the Plan, COBRA provides continuation of Plan coverage at the spouse’s expense if Plan coverage is lost because of:

- The death of the Retiree (although a Spouse/Same-Sex Domestic Partner is usually permitted to continue coverage under the Plan upon the Retiree’s death, so this qualifying event will generally not cause a loss of coverage); or
- Divorce from the Retiree.

**A Spouse/Same-Sex Domestic Partner and/or Dependent Children can elect and pay for COBRA coverage for up to 36 months if they are no longer eligible for coverage under the Plan.**

For a Dependent Child of a Retiree or the Surviving Spouse/Surviving Same-Sex Domestic Partner of a Retiree covered by the Plan, COBRA provides continuation of Plan coverage at the Dependent’s expense if Plan coverage is lost because of:

- The death of the Retiree or Surviving Spouse/Surviving Same-Sex Domestic Partner;
- The divorce of the Dependent Child’s parents (if the Dependent Child continues to meet the definition of Dependent, divorce or separation of the parents will generally not cause the Dependent Child to lose coverage); or
- An individual no longer meets the Plan’s definition of a Dependent Child.



## 2. Notify the Plan's Eligibility Benefits Center

A Retiree, Surviving Spouse/Surviving Same-Sex Domestic Partner, or Dependent Child must notify Retiree Health Care Connect of any qualifying events within 60 days of the event. Retiree Health Care Connect will then send a COBRA Election Notice. If the Retiree, Surviving Spouse/Surviving Same-Sex Domestic Partner, or Dependent Child does not notify Retiree Health Care Connect within 60 days of the qualifying event, he or she will lose the right to elect COBRA Continuation Coverage.

## 3. Electing COBRA Continuation Coverage

If your Dependents wish to elect COBRA Continuation Coverage, they must contact Retiree Health Care Connect no later than 60 days after the date that coverage ended, or, if later, the date they receive the General COBRA Continuation Coverage notice from the Plan.

Each Dependent eligible for COBRA Continuation Coverage has an independent right to elect this coverage. In general, a parent may elect to continue coverage for Dependent Children. However, a Dependent Child who is 18 years or older has the right to elect COBRA Continuation Coverage independently, regardless of whether or not you or your Spouse elects this coverage.

## 4. Paying for COBRA Continuation Coverage

Retiree Health Care Connect will notify your Dependents of the cost of COBRA Continuation Coverage when it notifies them of their right to coverage. The cost for COBRA Continuation Coverage will be determined by the Committee on a yearly basis.

The first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day coverage under the Plan ended. This payment is due no later than 45 days after the date the Dependents sign the election form and return it to Retiree Health Care Connect.

Subsequent payments are due the first of the month for which payment is made. If a monthly payment is made on or before its due date, coverage under the Plan will continue for that month without any break. A COBRA payment will be considered made when it is mailed (postmarked).

**If payment is not made by the required due date plus a grace period, coverage under the Plan will end. Once COBRA Continuation Coverage ends, it cannot be reinstated.**

### 5. Grace Periods For COBRA Payments

Although COBRA payments are due on the first day of the month, a grace period of 30 days is provided to make each COBRA payment. The grace period does not apply to the first COBRA payment, which is due within 45 days of election of COBRA continuation coverage, as noted above. COBRA continuation coverage will be provided for each month, as long as payment for that month is made before the end of the grace period. However, if a monthly payment is made later than the first day of the month to which it applies, but before the end of the grace period for the month, and the individual submits a claim within that period, the individual may receive an explanation of benefits that a benefit determination cannot be made due to a pending COBRA payment. This means that unless the Plan has received the COBRA payment, it will not pay benefits.

### 6. Dependents' Loss of COBRA Continuation Coverage

The period of COBRA Continuation Coverage for a Dependent may end or be reduced before 36 months if:

- The Dependent does not make the required monthly payment within 30 days of the due date;
- The Plan or Trust is terminated;
- The Dependent becomes covered under any other group health care plan after the date COBRA Continuation Coverage is elected (provided that plan does not contain any pre-existing condition exclusions or limitations that affect coverage);
- The Dependent voluntarily cancels coverage; or
- The Dependent becomes entitled to Medicare after the date he or she first elect COBRA Continuation Coverage.

NOTE: If a Dependent becomes entitled to Medicare prior to the date he or she is eligible to elect COBRA, the Dependent is still eligible to elect to continue coverage under COBRA. However, if the Dependent becomes entitled to Medicare after electing to continue coverage under COBRA, the Dependent's COBRA coverage will be terminated. Once coverage under COBRA has been terminated, it will not be reinstated.

If COBRA Continuation Coverage ends before the end of the 36-month COBRA Continuation Coverage period, the Dependents will be notified that their coverage has ended and the reason why it has ended.

If you have any questions about COBRA, you should contact Retiree Health Care Connect.

## **B. PRIVACY PROTECTION UNDER HIPAA**

### 1. Privacy and Security of Your Information

The Plan follows the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) to protect the privacy and security of your health information.

For a more thorough understanding of your rights under HIPAA and/or how the Plan uses your personal health information while providing you and others in the Plan with care, read the most recent version of the Plan's "Notice of Privacy Practices." You should have been sent a copy of this Notice with this SPD if you are new to the Plan or within the last few years if you are an existing member. If you would like a new copy, you can:

- (a) Go online to <http://www.uawtrust.org/documents> and download it from there;
- (b) Contact Retiree Health Care Connect for a copy; or
- (c) Send a letter to Privacy Official, UAW Retiree Medical Benefits Trust, P.O. Box 14309, Detroit, MI 48214, requesting a copy.

The Plan's obligation to protect your health information includes your "genetic information" under the Genetic Information Nondiscrimination Act (GINA). The Plan will treat your genetic information as protected health information and will not use your genetic information for underwriting purposes (e.g., we won't deny you coverage or increase your Contributions because you might have an inherited disease).

The Plan takes its obligations under HIPAA seriously. The privacy and security of your information is a fundamental concern anytime your personal health information is used or disclosed. The Plan also requires that each of its service providers (e.g., Blue Cross Blue Shield of Michigan or Retiree Health Care Connect) that has access to your information handle it with the same care and concern as the Plan.

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Privacy Official at the address listed above. You may also file a complaint with the Secretary for the U.S. Department of Health and Human Services. Instructions on how to do so are in the Notice of Privacy Practices, as well as online at <http://www.hhs.gov>.

## 2. Other Rights under HIPAA

If you want additional information about your rights under HIPAA, you can get help from the Regional Office of the Employee Benefits Security Administration, a division of the U.S. Department of Labor. You can find this office online at <http://www.askebsa.dol.gov> or by calling 1-866-444-3272. You can also call your Carrier.

## 3. Privacy Laws outside of the United States

In addition to HIPAA, there are various other laws that may regulate the use of data related to you. By participating in the Plan, you agree to the use of data related to you to by the Plan. While the Plan may provide services to you to the extent consistent with the terms of the Plan while you are in a foreign country, it is not the Plan's intent that it becomes subject to data privacy laws outside of the U.S.

For example, the European Union issued the General Data Privacy Regulation ("GDPR") which regulates the use of data for entities that offer services to data subjects in the European Economic Area. If you travel to or reside in the European Economic Area and receive medical treatment, visit the Plan's website, or otherwise interact with or receive benefits under the Plan, it is intended that GDPR will not apply. By participating in the Plan, you agree that all use of your data by the Plan will be considered under the laws, and you consent that the only limitations on the use of your data by the Plan shall be related to the laws of the U.S. You waive any and all rights or claims arising from the gathering, storage, or use of data related to you that you may have under the application of any statute or regulation other than that of the U.S.

## C. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans generally may not, under Federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan for prescribing a length of stay in excess of 48 hours (or 96 hours).

If you are enrolled in an HMO or MA plan, your plan may have additional required benefits under applicable State law.

## D. SUBROGATION AND REIMBURSEMENT

The Plan will pay for your benefits as normal if you need health care due to the actions or inactions of another person. Some examples of this may be injuries from a car accident or a physician's malpractice. The Plan may coordinate these benefits with another insurer, for example an auto insurer, at the time you seek care. See the section on Coordination of Benefits for more information on how that works.

If there is another party potentially responsible for paying your health benefits, the Plan may pursue that party for recovery. Or you may file a lawsuit or complaint against such a person, company, or other party to recover your costs and to pay you for any pain and suffering. In that case, the Plan has a right to repayment of any funds it spent on your health care and recovery from that event. This is called "subrogation" or a "right of recovery."

If benefits are paid under the Plan and another party's action or inaction was responsible for you or your Dependents having incurred the expenses, the Plan is entitled to be subrogated to you, your Dependents, or your estate's rights to recover damages for such benefits (e.g., automobile accidents that cause medical expenses to be incurred). In that way, financial liability remains where it belongs – with the party responsible for incurring the expenses – while the Plan's costs are reduced.

The Plan has the right to 100% of the amount of recovery that you receive from a third party before any other party is compensated, with an exception for the Federal Government under Medicare. The Plan's recovery cannot be reduced for any equitable defense, including but not limited to the made-whole doctrine, the common fund doctrine, estoppel, or waiver. See the corresponding section of the Plan Document for more information.

If you or your Dependents are involved in such a situation, you are required to provide the Plan with whatever assistance is necessary to recover payments made on behalf of the Plan, including providing information regarding the event and cooperating with the Plan.

If you have hired an attorney, and you and your attorney agree to honor the Plan's right to recovery (called a "first priority lien") during any court proceedings, negotiations, or similar procedures, the Plan will consider reducing the amount of its recovery to allow for your attorney's fees or court costs. To take advantage of this, you must have an express written authorization from the Plan or its representative. The Plan will have a first priority lien on any recovery from a third party. This lien is binding on any attorney, insurance company, or other party who agrees or is obligated to make payment to you or your Dependents as compensation for any damages. The lien exists at the time the Plan pays medical benefits. If you or your Dependent files a petition for bankruptcy, you or your Dependent agrees that the Plan's lien existed in time prior to the creation of the bankruptcy estate.

If you fail to repay the Plan, the Plan may offset future payments for medical services you receive by withholding payments until the entire amount due is reimbursed.

NOTE: If you are enrolled in an HMO or Medicare Advantage plan, this section does not apply to you, because the HMO or Medicare Advantage plan will apply its own subrogation and reimbursement rules. You should consult the materials from your Carrier on its subrogation rights.

## **E. IMPORTANT INFORMATION ABOUT THE TRUST AND PLANS**

### *1. Trust Name*

The Trust is known as the UAW Retiree Medical Benefits Trust.

### *2. Plan Names*

UAW Chrysler Retirees Medical Benefits Plan  
 UAW Ford Retirees Medical Benefits Plan  
 UAW GM Retirees Medical Benefits Plan

### *3. The Committee of the UAW Retiree Medical Benefits Trust (Committee)*

A Committee is responsible for the operation of the Trust and the Plans. The Committee consists of six Independent members and five members chosen by the UAW.

All correspondence to the Committee or any individual member of the Committee should be sent to the UAW Retiree Medical Benefits Trust at P.O. Box 14309, Detroit, MI 48214.

### *4. Trustee*

The Trustee is State Street Bank. Address: State Street Bank and Trust Company, 200 Newport Ave., JQB7S, North Quincy, MA 02172

### 5. Plan Sponsor, Plan Administrator, and Named Fiduciary

The Committee acts as both the Plan Sponsor and the Plan Administrator on behalf of the UAW Chrysler Retirees Employees' Beneficiary Association, the UAW Ford Retirees Employees' Beneficiary Association and the UAW GM Retirees Employees' Beneficiary Association. The Committee is also the named fiduciary for the Plans. The Committee has delegated administrative responsibility for day-to-day operation of the Plan to its Executive Director, service providers, Carriers, the Trust's workforce, and to Retiree Health Care Connect. Contact information for these entities is provided in Section XI.

### 6. Identification Numbers

The Employer Identification Number (EIN) assigned to the Committee by the Internal Revenue Service is 90-0424876. The Plan Numbers (PNs) assigned to these Plans by the Committee are:

UAW Ford Retirees Medical Benefits Plan – 502

UAW Chrysler Retirees Medical Benefits Plan – 503

UAW GM Retirees Medical Benefits Plan – 504

### 7. Agent for Service of Legal Process

Service of legal process may be made upon the Plan Administrator, UAW Retiree Medical Benefits Trust, P.O. Box 14309, Detroit, Michigan 48214.

### 8. Priority of Plan Documents

This Summary Plan Description booklet is meant to be an easy-to-understand description of your benefits. If there is any discrepancy between this summary and the Plan Document, the Plan Document controls. If there is any discrepancy between this SPD Summary Plan Description and any Schedules of Benefits, or Benefit Highlight Letters, Summaries of Material Modifications or Certificates or Evidences of Coverage (for an HMO or Medicare Advantage option), the Schedule of Benefits, Benefit Highlight Letters, Summaries of Material Modifications, or Certificate or Evidence of Coverage, as applicable, will govern.

This Summary Plan Description is a summary of the Plan Documents. The Plan Documents contain a more detailed description of the benefits summarized here (which can be obtained at <https://www.uawtrust.org/documents>).

### 9. Contribution Source

Plan benefits described in this booklet are provided through a Voluntary Employees' Beneficiary Association Trust funded through contributions as established pursuant to court-approved settlement agreements between the Auto Companies and the UAW and the Trust Agreement.



## 10. Administration

Except where provided under an HMO option or a Medicare Advantage plan, benefits under the Plans are administered by third party Carriers under an administrative services agreement with the Trust. HMOs and Medicare Advantage plans are administered by insurers. The HMOs and the Medicare Advantage Plans are fully-insured. The remaining plans are self-funded.

## 11. Trust Fund

All assets are held in trust by the Committee for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

## 12. Plan Type

This Plan is maintained to provide Hospital, surgical, medical, and prescription drug coverage, and, in some cases, other coverage for Primary Enrollees and Dependents who meet the eligibility requirements. The Trust is a tax-exempt employee welfare benefit fund, known under Section 501(c)(9) of the Internal Revenue Code, as amended, as a “Voluntary Employees’ Beneficiary Association” or “VEBA.” Trust benefits are described in this Summary Plan Description and additional details are listed on the Schedule of Benefits.

## 13. Plan Year

The Plan Year and the Trust’s benefit year are the calendar year that begins on January 1 and runs through the following December 31. Records relating to benefits are kept on a calendar year basis.

## 14. Plan Funding

The benefits provided by the Plan are funded through the Trust. HMO and Medicare Advantage benefits are fully insured and paid by the applicable insurer.

## 15. Plan Amendment or Termination of the Trust

The Plan may be amended, changed, or discontinued at any time by the Committee, subject to the limitations of the Plan Document, applicable Settlement Agreements, the Trust Agreement, and applicable law and administrative regulations. Absent an express delegation of authority from the Committee, no one has the authority to commit the Trust to any benefit or benefit provision not provided for, or to change the eligibility criteria or any other provisions of the Plan.

You and your eligible Dependents do not acquire any vested right to Plan benefits either before or after your retirement. The Committee may, and they reserve the right to:

- Amend or terminate the Plan or Trust;
- Expand, reduce, or cancel coverage for participants;
- Change eligibility requirements; and
- Otherwise exercise prudent discretion at any time without legal right or recourse by you, your Dependents, or any other person.

The Committee may modify or terminate the Trust as permitted by the Trust Agreement and applicable law. If the Trust is terminated, any and all assets remaining after the payment of all obligations and expenses will be used, in accordance with the rules set forth in the Trust Agreement. The Committee may terminate the Plan for a separate retiree account as provided by the Trust Agreement. If a separate retiree account is terminated, retirees receiving benefits under that account will no longer be eligible for coverage under the Plan.

#### 16. Summary of Plan Provisions Upon Termination of the Trust

The Committee is empowered to terminate the Trust, the Plans, and the underlying accounts funding the Plans. The Committee will do so when it determines, in its sole discretion, that the Trust is no longer effectively serving its purposes or that the interests of the Participants and the Beneficiaries could be better served through an alternative arrangement. In paying out the assets of the Trust, the Committee is required to recognize this priority of funding: (1) the payment of reasonable and necessary administrative expenses (including taxes); (2) the payment of Benefits to Participants and Beneficiaries entitled to payments for claims arising prior to such termination; and (3) for the benefit of the Participants and Beneficiaries in such fashion as the Committee determines, in accordance with section 501(c)(9) of the Internal Revenue Code. The Committee will continue distribution until all assets have been liquidated.

#### 17. Plan Interpretation

The Committee has the discretion to determine eligibility for benefits and to interpret the terms of the Trust and/or this Plan, including ambiguous terms. The decisions of the Committee as to the granting or denial of benefits and the construing of terms of the Trust are reviewed under the “arbitrary and capricious” standard of judicial review by a reviewing court as set forth by the United States Supreme Court in *Firestone and Rubber Company, et al. v. Richard Bruch*.

#### 18. Parties Having Authority as to Benefits under the Plans

The Committee is the ultimate authority on the benefits described in this Summary. The Committee has delegated interpretive authority to the Trust employees. Former employers, union representatives, or similar individuals may have useful information about the benefits under the Plans, but they are not authorities on the Plan benefits and do not bind the Plan.

### 19. Change in Eligibility Rules of the Trust

The Committee is empowered to change or amend the Trust's eligibility rules, the benefits described in this booklet, or any other Trust provision in accordance with the Plan Document, as the Committee, in its sole discretion, determines to be necessary. You will be notified in writing of any changes to the program of benefits. None of these benefits are vested.

### 20. Right to Ask about a Particular Employer

Participants have a right to make inquiries of the Trust, and may do so by writing to the Plan Administrator, UAW Retiree Medical Benefits Trust, P.O. Box 14309, Detroit, MI 48214, as to whether any particular employer has retirees in the Trust. No employers are active sponsors of the Trust or the Plans. The Trust is the sponsor of the Plans.

### 21. Plan's Right to Recover an Overpayment

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan, or its Carrier, will try to collect the overpayment from the party that received the payment. However, the Plan reserves the right to seek overpayment from any member or their Dependent(s). In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments.

If the overpayment is made to a provider, the Plan, or its Carrier, may reduce or deny benefits, in the amount of the overpayment, for otherwise covered services for current and/or future claims with the provider on behalf of any member or their Dependent(s). The Carrier may offset payments to the provider that was overpaid, including payments that the Carrier would make to that provider for patients that are not members of the Plan or vice versa.

### 22. State Law Preemption

With regards to any self-insured benefit under the Plan, state laws are preempted. This means that no state law-based mandated benefit or benefit design shall apply. In any case where state law must apply to these benefits, the laws of the State of Michigan shall apply.

### 23. Uncashed Checks issued to Participants

A member that has received a check from a Carrier or other entity, such as the Eligibility Administrator, on behalf of the Plan should cash that check promptly. In any case, at some point, that check will no longer be valid. You should contact the Carrier or entity that issued the check to determine when your check expires.

## F. YOUR RIGHTS UNDER ERISA

As a Participant in the Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all participants are entitled to certain rights, as described in this section.

### 1. Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Trust Office and at other specified locations, all documents governing the Trust. These include insurance contracts 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.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan's operation. These include insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description/Plan Document. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

### 2. Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for you, your spouse, or your dependents if there is a loss of coverage under the Plan because of a qualifying event. Your dependents may have to pay for such coverage. Review this Summary Plan Description/Plan Document and other documents governing the Plan on the rules governing COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the Plan;
  - You become entitled to elect COBRA continuation coverage; or
  - Your COBRA continuation coverage ends.

You must request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage under a new plan.

### 3. 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 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 the Trust, your union, or any other person, may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### 4. 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.

Under ERISA, there are steps you can take to enforce the above rights. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan’s claims and appeals procedures. For instance, if you request a copy of the Summary Plan Description/Plan Document 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.

### 5. 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 nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor. You may also contact the National EBSA Office at:

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

You may also obtain certain publications about your rights and responsibilities under ERISA, or a list of EBSA offices, by visiting the EBSA web site at <http://www.dol.gov/ebsa>.

## G. NON-RETALIATION

The Plan will take no action or discrimination against you or your Dependents for reporting or attempting to report a response to an inquiry or a proceeding of a court of appropriate jurisdiction, governmental agency, or member of the Plan.

You or your Dependent must report honestly and in good faith. If you or your Dependent believe that the Plan has violated some law or internal Plan policy, but you or your Dependent does not wish to be known as the source of the complaint, you or your Dependent can call the compliance hotline (“Compliance Line”) at 1-888-250-6617. The Plan will investigate all inquiries.

## H. MARKETPLACE COVERAGE

You have a right to decline coverage under the Plan and seek coverage under the Health Insurance Individual Marketplaces, as established by the Patient Protection and Affordable Care Act. However, you will likely not receive any premium subsidy from the Federal Government to offset the cost of coverage of one of these plans. The Plan will not contribute to your coverage in one of these plans either.

## I. NON-DISCRIMINATION RIGHTS

The UAW Retiree Medical Benefits Trust complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Trust does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Trust:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters (through a video relay)
  - Written information in other formats (large print, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need help, contact Retiree Health Care Connect at 866-637-7555 [TTY – 800-325-0778].

If you believe that the Trust has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Compliance Department, UAW Retiree Medical Benefits Trust, P.O. Box 14309, Detroit, MI 48214. You can file a grievance by mail or by fax at 313-324-5850. If you need help filing a grievance, the Compliance Department of the Trust will do its best to assist you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



[English]

Tagline: If you need help or answers in this language or another, please call Retiree Health Care Connect at 866-637-7555. You can receive assistance there and ask questions, without cost, in this language and many others.

[Español]

Si necesita ayuda o respuestas en este u otro idioma, llame a Retiree Health Care Connect al 866-637-7555. Allí le brindarán asistencia y podrá hacer preguntas, sin costo, en este idioma y en muchos más.

[中文]

如果您需要我們以本語言或其他語言提供協助或答案，請致電 866-637-7555 與 Retiree Health Care Connect 聯絡。您可透過撥打此電話號碼免費以本語言及其他許多語言取得協助和提問。

[Tiếng Việt]

Nếu quý vị cần hỗ trợ hoặc cần được giải đáp thắc mắc bằng ngôn ngữ này hoặc ngôn ngữ khác, vui lòng gọi Retiree Health Care Connect theo số 866-637-7555. Quý vị có thể nhận được trợ giúp qua đường dây đó và đưa ra các thắc mắc mà không mất phí, bằng ngôn ngữ này và nhiều ngôn ngữ khác.

[한국어]

**이 언어 또는 다른 언어로 도움 혹은 답변이 필요한 경우, Retiree Health Care Connect 에 866-637-7555 번으로 전화해 주십시오. 이곳에서 무료로 이 언어를 포함한 다른 여러 언어로 도움을 받고 질문을 물어볼 수 있습니다.**

[Tagalog]

Kung kailangan ninyo ng tulong o mga sagot sa wikang ito o sa isa pang wika, mangyaring tawagan ang Retiree Health Care Connect sa 866-637-7555. Makakatanggap kayo doon ng tulong at makakapagtanong nang walang babayaran, sa wikang ito at marami pang iba.

[Русский]

Если вы хотите, чтобы вам помогли или ответили на вопросы по-русски или на каком-то другом языке, позвоните в центр «Медицинское обслуживание пенсионеров» (Retiree Health Care Connect), телефон 866-637-7555. Вам бесплатно помогут и ответят на вопросы по-русски или на одном из многих других языков.

[Kreyòl Ayisyen]

Si ou bezwen asistans oswa repons nan lang sa a oswa yon lòt lang, tanpri rele Retiree Health Care Connect nan 866-637-7555. Ou kapab jwenn asistans la ak poze kesyon, gratis, nan lang sa a ak plizyè lòt lang.

[Português]

Se você precisar de ajuda ou respostas nesta língua ou em outra, ligue para Retiree Health Care Connect no número 866-637-7555. Lá é possível receber assistência e fazer perguntas, sem custos, nesta língua e em muitas outras.

[Français]

Si vous avez besoin d'aide ou de réponses dans cette langue ou dans une autre, veuillez communiquer avec Retiree Health Care Connect au (866) 637-7555. Vous pourrez recevoir de l'aide et poser des questions, sans frais, dans cette langue et dans plusieurs autres.

[Polski]

Jeśli potrzebujesz pomocy lub odpowiedzi na pytania w tym albo w innym języku, prosimy o kontakt telefoniczny z Retiree Health Care Connect pod numerem 866-637-7555. Pod tym numerem możesz otrzymać bezpłatną pomoc i zadać pytania w tym i w wielu innych językach.

[日本語]

この言語か別の言語でご支援が必要な場合、またはご質問がある場合はRetiree Health Care Connect（電話番号：866-637-7555）までお問い合わせください。ここから、無料のご支援やお問い合わせにこの言語や他の言語で対応しています。

[Italiano]

Se ha bisogno di aiuto o di risposte in questa lingua o in un'altra, la preghiamo di chiamare Retiree Salute Care Connect al numero 866-637-7555. Lì può ricevere assistenza e fare domande, senza alcun costo, in questa lingua e in molte altre.

[Deutsch]

Falls Sie Hilfe oder Antworten in dieser oder einer anderen Sprache benötigen, rufen Sie bitte Retiree Health Care Connect unter 866-637-7555 an. Sie können dort in dieser und vielen anderen Sprachen kostenlose Unterstützung erhalten und Fragen stellen.

[عربي غللا]

زكرب لاصتالاء اجرلا، یرخأ ةغل ةيأ وأ ةغللا هذبه تاباجإ ىلع لوصحلا وأ ةدعاسملا تدرأ اذا كانه ةدعاسملا ىلع لوصحلا كئناكمإب. 866-637-7555 مقرلا ىلع Retiree Health Care Connect. یرخال تاغللا نم ديدعلا او ةغللا هذبه، موسر ةيأ نودب ةلئسأ ةيأ حرطو.

یسراف

اب أفطل، دیراد زاین یرگی د نابز ای نابز نی هب یی اه خساپ ای کمک هب رگا اجنأ رد دیناوت یم امش. دیری گب سامت 866-637-7555 هرامش هب Retiree Health Care Connect و دینک تفایرد یی امنهار و کمک ناگیار روط هب رگی د یی اه نابز یرای سب و نابز نی هب ار یتال اؤس

## X. QUICK REFERENCES

### A. DEFINITIONS

This section contains definitions of important terms used throughout this SPD. When these terms are capitalized in this booklet they have the meanings shown below.

#### Accidental Injury

A bodily injury (such as a fracture, strain, sprain, abrasion, contusion, or other condition) caused by an action, object, or chemical agent. It may occur as the result of a traumatic incident, such as being struck, or by other events such as, but not limited to: ingestion of poison; overdose of medication, whether accidental or intentional; allergic reaction resulting from trauma, such as bee stings or insect bites; inhalation of smoke, carbon monoxide, or fumes; burns, frostbite, sunburn, and sunstroke; and attempted suicide.

#### Allowed Amount

The maximum amount the Plan will pay for a specific covered service, according to certain standards and considerations. In-Network Providers have agreed to accept this Allowed Amount as payment in full even though their billed charge may be more.

#### Approved Facility or Treatment Program

A facility or treatment program that has met criteria established by the Carrier for your Plan to provide certain services covered under the Plan.

#### Auto Company

One of the following companies: Chrysler Group LLC (now known as Fiat Chrysler Automobiles N.V.), Ford Motor Company, or General Motors Company, and certain companies or organizations affiliated with them.

#### Carrier

An entity that pays benefits and/or administers a coverage plan option under the Trust, including, but not limited to, a Blue Cross Blue Shield plan, a commercial insurance company, a Health Maintenance Organization (HMO), a Medicare Advantage Organization (MAO), a Preferred Provider Organization (PPO), a Pharmacy Benefit Manager (PBM), or an administrative services provider.

A Carrier enters into contracts with various types of Providers who agree to accept the Allowed Amount as payment in full for covered services provided by the Provider. These providers are referred to as “In-Network Providers.”

### Case Management

Case management is a program for our members to get the help they need when they are ill. The Plan, working through your Carrier, offers services under which a nurse case manager or other health professional helps you get proper care, achieve better health, and reduce unnecessary or unwanted care. Case management does not replace or overrule the advice of your doctor, but provides support as you navigate through the healthcare system. When you participate in the Case Management program, a nurse or other health professional will review your health care needs, help you to understand your options, and coordinate services to meet your health care goals. Case management services may be required in order to obtain certain services, such as transplants, or other complex care.

### Coinsurance

The member's share of the costs of a medical service, calculated as a percent (for example, 10%) of the Allowed Amount for the service, paid to the Provider. Coinsurance applies after the Deductible has been met until an applicable Out-of-Pocket Maximum is reached.

### Committee

The Committee was formed by operation of the court-approved settlement agreements between the Auto Companies and the UAW. The Committee acts on behalf of the Employees' Beneficiary Association (EBA) for each Auto Company with regard to retiree medical coverage. Each EBA, through the Committee, has established and maintains a separate employee welfare benefit plan, known as the UAW Chrysler Retirees Medical Benefits Plan, the UAW Ford Retirees Medical Benefits Plan, and the UAW GM Retirees Medical Benefits Plan, together or individually, as applicable, the "Plan."

### Contributions

The monthly amount you must pay in order to have coverage for yourself and your Dependents under the Plan. In general, the required Contributions will be deducted from your retirement payment. If you do not make your required monthly Contributions, you and your Dependents will lose your coverage at the end of the last month for which Contributions were made.

### Copay or Copayment

The set or fixed dollar amount you must pay for certain services. The amount varies depending on the service. For more information, see the Schedule of Benefits for your Plan.

### Custodial, Domiciliary, or Maintenance Care

The type of care or services which, even if ordered by a physician, are primarily for the purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to specific medical, surgical, or psychiatric care or services designed to reduce the disability to the extent necessary to enable the patient to live without such care. Custodial, Domiciliary, or Maintenance care can be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating, and taking medication; ostomy care, hygiene, or incontinence care; and checking of routine vital signs.

### Deductible

An amount you owe for certain health care services before the Plan will begin to pay for those services. The deductible does not apply to every service. For more information, see the Schedule of Benefits for your Plan.

### Dependent(s)

The Primary Enrollee's eligible Spouse, Same-Sex Domestic Partner, and Dependent Children.

### Dependent Child (Dependent Children)

Generally, a child whom the Primary Enrollee can legally claim as an exemption on his or her federal income tax return. To be eligible for coverage under the Trust, the child must meet the eligibility requirements in Section I "Eligibility for Dependent Children."

### Employer/Union-Group Waiver Plan (EGWP)

The Medicare Part D Prescription Drug Plan sponsored by the Trust for its Medicare Enrollees and their Medicare Dependents. The name comes from a certain "waiver" that Medicare has granted the Trust in order to offer the Part D Plan.

### Experimental and/or Investigational

A service or supply that meets any of the following conditions, as determined by the applicable Carrier:

- The service or supply is described as an alternative to more conventional therapies in the protocols or informed consent document of the Provider that performs the service or prescribes the supply;
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
- There is an absence of authoritative medical or scientific literature on the subject;
- A significant amount of authoritative medical or scientific literature published in the United States shows that medical or scientific experts classify the service or supply as experimental or investigational or indicate that more research is required;
- The Food and Drug Administration (FDA) has not granted approval of the service or supply (if such FDA approval is required);
- The service or supply exceeds an FDA-approved limit; or
- The service or supply is available only through participation in clinical trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

### Formulary

A list of the prescription drugs covered by the Plan, broken into tiers by type of manufacturer (brand versus generic). A formulary is a list of the drugs, dosages, strengths, and plan limitations that apply to a Plan.

### Freestanding Outpatient Physical Therapy Facility

A facility, separate from a Hospital, which provides outpatient physical therapy services. To receive In-Network benefits for services received at a Freestanding Outpatient Physical Therapy Facility, it must have a contract with the Carrier for your Plan.

### Home Health Care Agency

A centrally administered agency providing physician directed nursing and other paramedical services to patients at home. To receive In-Network benefits for services received from a Home Health Care Agency, it must have a contract with the Carrier for your Plan.

### Hospice

A program of medical and non-medical services provided for terminally ill enrollees and their families through agencies that administer and coordinate the services. To receive In-Network benefits for services from a Hospice program, it must have a contract with the Carrier for your Plan.

### Hospital

A facility that provides diagnostic and therapeutic services on a continuous inpatient basis for the surgical, medical, or psychiatric diagnosis, treatment, and care of injured or acutely sick persons. These services are provided by, or under the supervision of, a professional staff of licensed physicians and other health professionals. A Hospital continuously provides 24 hour a day nursing service by registered nurses. A rehabilitation institution is considered to be a Hospital if the institution is approved as such under this Plan by the applicable Carrier. A Hospital must meet all applicable local and state licensure and certification requirements and be accredited as a Hospital by state or national medical or Hospital authorities or associations. To receive In-Network benefits for services received at a Hospital, it must have a contract with the Carrier for your Plan.

### In-Network Providers

Providers that participate in the Traditional Care Network (TCN), Enhanced Care PPO (ECP), or other networks providing Plan coverage, such as HMOs and MA PPOs. In-Network Providers are also referred to as “Network Providers,” “Participating Providers,” or “Panel Providers.” Each Carrier contracts with Providers to form its own Network of Providers.



### Medical Emergency

A medical emergency is a health threatening or disabling condition that requires immediate medical attention and treatment. The condition must be of such a nature that severe symptoms occur suddenly and unexpectedly and that failure to render treatment immediately could result in significant impairment of bodily function, 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 medical emergency. To be a medical emergency, treatment must be sought within 72 hours of the onset of symptoms.

### Medically Necessary (Medical Necessity)

A service or supply that is all of the following (as determined by the applicable Carrier):

- provided by or under the direction of a health care practitioner who is authorized to provide or prescribe it;
- necessary in terms of generally accepted American medical standards;
- consistent with the symptoms or diagnosis and treatment of an illness or injury;
- not provided solely for the patient or Provider's convenience;
- appropriate given the patient's circumstances and condition;
- a "cost-efficient" supply or level of service that can be safely provided to the patient;
- safe and effective for the illness or injury for which it is used; and
- not considered Experimental or Investigational.

### Medicare Providers

Providers that are approved by Medicare to treat Medicare-eligible individuals and that accept the Medicare Allowed Amount as payment in full. Medicare Providers accept assignment of Medicare payments by billing Medicare directly.

### Out-of-Network Providers

Providers that do not participate in the Traditional Care Network (TCN), Enhanced Care PPO (ECP), or other networks providing Plan coverage, such as HMOs and MA PPOs. When you use an Out-of-Network Provider, you generally are responsible for paying the applicable Out-of-Network Deductible and Coinsurance, as well as any amounts in excess of the Allowed Amount. Out-of-Network Providers also are referred to as "Non-Network Providers," "Non-Participating Provider," or "Non-Panel Providers." Out-of-Network Providers are specific to the Carrier for each Plan.

### Out-of-Pocket Maximum

A limit on the amount you pay during a year after which the Plan will pay for your covered services at 100%. Some cost-sharing – coinsurance and deductibles – from In-Network Providers counts toward your Out-of-Pocket Maximum. A separate Out-of-Pocket Maximum may apply for In-Network services and Out-of-Network services.

### Outpatient Freestanding Facility

A facility, separate from a Hospital, which provides outpatient services. To receive In-Network benefits for services received at an Outpatient Freestanding Facility, it must have a contract with the Carrier for your Plan.

### Partial Hospitalization Treatment Facility

Facility that provides a semi-residential level of care for patient with mental health or substance abuse disorders who require coordinated intensive, comprehensive, and multidisciplinary treatment in a structured setting, but less than full time hospitalization. The patient undergoes therapy for more than four hours a day, and may receive additional services (e.g., meals, bed, recreation). To receive In-Network benefits for services received at a Partial Hospitalization Treatment Facility, it must have a contract with the Carrier for your Plan and be preapproved.

### Participating Provider

A Provider that has an arrangement with a Carrier for a particular fee or particular method of payment. For some Carriers, the term is used the same as “In-Network Provider,” but for some benefits, such as with Hospitals, “Participating Providers” represent a larger group of Providers that have not necessarily agreed to be in the Carrier’s network.

### Plan

The UAW Chrysler Retirees Medical Benefits Plan, the UAW Ford Retirees Medical Benefits Plan, or the UAW GM Retiree Medical Benefits Plan, as applicable.

### Primary Care Physician (PCP)

A physician specializing in Family Medicine, Internal Medicine, Obstetrics-Gynecology, Gerontology, or Pediatrics who provides definitive care to the patient at the point of first contact, and takes continuing responsibility for providing the patient’s comprehensive care. This care may include chronic, preventive, or acute care in either inpatient or outpatient settings.

### Primary Enrollee

The person who is enrolled in a Plan and whose Dependents are eligible for coverage because of the person’s enrollment. The Primary Enrollee may be a Retiree, a Surviving Spouse, or a Surviving Same-Sex Domestic Partner.

### Provider

A person (such as a doctor) or a facility (such as a Hospital) that provides health care services. Providers are considered “in-network” when they have signed an agreement with a Carrier to accept the Allowed Amount for a service as “payment in full.”

### Residential Substance Abuse Treatment Facility

Facility that provides inpatient facility treatment for a patient with substance abuse disorders. To receive In-Network benefits for services received at a Residential Substance Abuse Treatment Facility, it must have a contract with the Carrier for your Plan and be preapproved.

### Retail Clinic

A walk-in medical facility often located in a pharmacy or a retail store (such as CVS, Walgreens, or Target) where nurse practitioners deliver care and advice on simple illnesses or injuries.

### Retiree Health Care Connect

The service provider hired by the Trust to administer the Trust’s eligibility rules and provide service and support to the members through an online portal and call center. Retiree Health Care Connect was formerly known as the Eligibility Benefits Center.

### Settlement Agreement

The Settlement Agreements and the Agreement creating the Trust can be found at the Trust’s website <http://www.uawtrust.org/history>.

### Skilled Nursing Facility

A facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a physician and a registered nurse. The facility may be operated either independently or as part of an accredited general Hospital. To receive In-Network benefits for services received at a Skilled Nursing Facility, it must have a contract with the Carrier for your Plan.

### Specialist

A physician who provides health care services beyond the scope of primary care for a specific disease or part of the body. These physicians cover those specialties not covered by Primary Care Physicians, for example Cardiology, Endocrinology, Dermatology, or Orthopedics.

### Spouse

A same-sex or opposite-sex individual married to a Retiree with a valid marriage certificate from a state, the District of Columbia, a U.S. territory, or a foreign country (“Jurisdiction”) where such marriage has been recognized as legal according to the laws of that Jurisdiction, regardless of whether the individual or the Retiree is a current resident of that Jurisdiction.

### Trust

The UAW Retiree Medical Benefits Trust, as operated by the Committee pursuant to the terms of the court-approved settlement agreements between the UAW and Chrysler Group LLC, Ford Motor Company, and General Motors Company, and as thereafter amended by the Committee. The Trust also may be referred to as a VEBA.

### UAW

The International Union, United Automobile, Aerospace and Agricultural Implement Workers of America.

### United States (U.S.)

The United States or U.S. is defined as encompassing all territories that have applied and been granted statehood to be a part of the U.S. and all territories that have been determined by the U.S. State Department to be property of the U.S., including the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and any other territory so determined.

### Urgent Care

Care which is needed for an unforeseen acute or serious illness, injury, or condition such that a prudent layperson would seek medical attention within 12-24 hours but which poses no immediate threat to life or health.

### Urgent Care Facility

A facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor emergency and episodic medical care, in which one or more physicians, nurses, and other health professionals are in attendance at all times when the facility is open. An Urgent Care Facility typically includes X-ray and laboratory equipment and a life support system.

VEBA

A Voluntary Employees’ Beneficiary Association, which is a tax-exempt employee welfare benefit fund that is held in trust for the benefit of covered participants.

You

The person who is the Primary Enrollee under the Plan. It refers to a Retiree, a Surviving Spouse, or a Surviving Same-Sex Domestic Partner.

**B. CONTACT INFORMATION**

<b>Mailing Address for the Trust</b>	Plan Administrator UAW Retiree Medical Benefits Trust P.O. Box 14309 Detroit, MI 48214
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**Call Centers**

<b>Retiree Health Care Connect</b>	866-637-7555 <a href="http://www.uawtrust.org">http://www.uawtrust.org</a> , follow the “Contact Us” link to find a link to RHCC
<b>Medicare</b> Centers for Medicare & Medicaid Services	800-MEDICARE (800-633-4227) TTY: 877-486-2048 <a href="https://www.medicare.gov">https://www.medicare.gov</a>
<b>Social Security Administration</b>	800-772-1213 TTY: 800-325-0778 <a href="http://www.ssa.gov">http://www.ssa.gov</a>

# CARRIERS

## Traditional Care Network and Prescription Drug Coverage

Health Plan Carrier Name	Claim Inquiries	Appeals
<p><b>Blue Cross Blue Shield of Michigan</b> (TCN)</p> <p>877-832-2829  <a href="http://www.bcbsm.com/uawtrust">http://www.bcbsm.com/uawtrust</a></p>	<p>UAW Auto Retiree Service Center            P.O. Box 311088            Detroit, MI 48231</p>	<p>UAW Auto Retiree Appeals Unit – Mail Code 2004            Blue Cross Blue Shield of Michigan            600 Lafayette East            Detroit, MI 48226</p>
<p><b>Blue Cross Blue Shield of Michigan</b> (ECP)</p> <p>866-507-2850  <a href="http://www.bcbsm.com/uawtrust">http://www.bcbsm.com/uawtrust</a></p>	<p>UAW Auto Retiree Service Center            P.O. Box 311088            Detroit, MI 48231</p>	<p>UAW Auto Retiree Appeals Unit – Mail Code 2004            Blue Cross Blue Shield of Michigan            600 Lafayette East            Detroit, MI 48226</p>
<p><b>New Directions</b>            (Mental Health/Substance Abuse Administrator)</p> <p>877-228-3912  <a href="http://www.ndbh.com">http://www.ndbh.com</a></p>	<p>UAW Auto Retiree Service Center            P.O. Box 311088            Detroit, MI 48231</p>	<p>New Directions Behavioral Health            ATTN: Appeals Coordinator            P.O. Box 6729            Leawood, KS 66206</p>
<p><b>Express Scripts</b>            (Pre-Medicare Prescription Drug Administrator) (PBM)</p> <p>866-662-0274  <a href="http://www.express-scripts.com">http://www.express-scripts.com</a></p>	<p>Express Scripts            ATTN: Commercial Claims            P.O. Box 14711            Lexington, KY 40512-4711</p>	<p><b>Administrative Appeals</b>            Express Scripts            P.O. Box 66587            St. Louis, MO 63166-6587            Attn: Administrative Appeals Department            Phone: 800-946-3979</p> <p><b>Clinical Appeals</b>            Express Scripts            P.O. Box 66588            St. Louis, MO 63166-6588            Attn: Clinical Appeals Department            Phone: 800-935-6103</p>
<p><b>Express Scripts Part D Plan</b>            (Medicare Prescription Drug Administrator) (PBM)</p> <p>866-662-0274  <a href="http://www.express-scripts.com">http://www.express-scripts.com</a></p>	<p>Express Scripts            ATTN: Medicare Part D            P.O. Box 14711            Lexington, KY 40512-4711</p>	<p><b>Administrative Appeals</b>            Express Scripts            P.O. Box 66587            St. Louis, MO 63166-6587            Attn: Administrative Appeals Department            Phone: 800-413-1328</p> <p><b>Clinical Appeals</b>            Express Scripts            P.O. Box 66588            St. Louis, MO 63166-6588            Attn: Clinical Appeals Department            Phone: 800-935-6103</p>



## Medicare Advantage PPOs

Health Plan Carrier Name	Claim Inquiries	Appeals
<p><b>Aetna</b> (MA PPO)</p> <p>1-800-663-0885  <a href="http://uawtrust.aetnamedicare.com/">http://uawtrust.aetnamedicare.com/</a></p>	<p>Aetna                      P.O. Box 981106                      El Paso, TX 79998-1106</p>	<p>Aetna Medicare Grievance and Appeal Unit                      P.O. Box 14067                      Lexington, KY 40512                      1-800-932-2159  <a href="http://www.aetnamedicare.com">http://www.aetnamedicare.com</a></p>
<p><b>Blue Cross Blue Shield of Michigan</b> (MA PPO)</p> <p>Customer Service                      888-322-5616  <a href="http://www.bcbsm.com">www.bcbsm.com</a>  <a href="http://www.bcbsm.com/uawtrust">www.bcbsm.com/uawtrust</a></p>	<p>Blue Cross Blue Shield of Michigan                      Imaging and Support Services                      P.O. Box 32593                      Detroit, MI 48232-0593</p>	<p>Blue Cross Blue Shield of Michigan                      Grievances and Appeals Department                      P.O. Box 2627                      Detroit, MI 48231-2627</p>

## Dental, Vision, and Hearing Carriers

Health Plan Carrier Name	Claim Inquiries	Appeals
<p><b>Delta Dental</b>                      (Dental Administrator)</p> <p>800-524-0149  <a href="http://www.deltadentalmi.com">http://www.deltadentalmi.com</a></p>	<p>Delta Dental                      P.O. Box 9089                      Farmington Hills, MI 48333-9089</p>	<p>Dental Director                      Delta Dental                      P.O. Box 30416                      Lansing, MI 48909-7916</p>
<p><b>Davis Vision</b>                      (Vision Administrator)</p> <p>888-234-5164  <a href="http://www.davisvision.com">http://www.davisvision.com</a></p>	<p>Vision Care Processing Unit                      P.O. Box 1525                      Latham, NY 12110</p>	<p>Davis Vision Quality Assurance                      P.O. Box 791                      Latham, NY 12110-0791</p>
<p><b>TruHearing</b>                      (Hearing Benefit Administrator)</p> <p>844-394-5420  <a href="http://www.truhearing.com/uawtrust">http://www.truhearing.com/uawtrust</a></p>	<p>TruHearing                      Attn: Grievance Team                      12936 Frontrunner Blvd Ste 100                      Draper UT 84020</p>	<p>TruHearing                      Attn: Grievance Team                      12936 Frontrunner Blvd Ste 100                      Draper UT 84020</p>
<p><b>Humana</b>                      (Hearing Benefit Administrator)</p> <p>800-758-5002  <a href="http://www.humana.com">http://www.humana.com</a></p>	<p>Humana Claims                      P.O. Box 14601                      Lexington, KY 40512-4601</p>	<p>Grievance and Appeals                      P.O. Box 14546                      Lexington, KY 40512-4546</p>

## Health Maintenance Organizations

Health Plan Carrier Name	Claim Inquiries	Appeals
<p><b>Blue Care Network Advantage Plan</b> (HMO-POS)</p> <p>800-222-5992 TTY users call 711 <a href="http://www.bcbsm.com/uawtrust">http://www.bcbsm.com/uawtrust</a></p>	<p>BCN Advantage Blue Care Network P.O. Box 68753 Grand Rapids, MI 49516-8753</p>	<p>BCN Advantage Appeals &amp; Grievance Unit Mail Code H305 Blue Care Network P.O. Box 284 Southfield, MI 48037-9887 FAX: 866-522-7345</p>
<p><b>Blue Care Network Plan</b> (HMO)</p> <p>800-222-5992 TTY users call 711 <a href="http://www.bcbsm.com/uawtrust">http://www.bcbsm.com/uawtrust</a></p>	<p>BCN Claims P.O. Box 68710 Grand Rapids, MI 49516-8710</p>	<p>BCN Grievance and Appeals Unit P.O. Box 284 Southfield, MI 48037-0284 FAX: 866-522-7345</p>
<p><b>Blue Cross Blue Shield of Kansas City</b> (HMO)</p> <p>816-395-3193 or 866-579-0864 <a href="http://www.BlueKC.com">http://www.BlueKC.com</a></p>	<p>P.O. Box 419169 Kansas City, MO 64141</p>	<p>Appeals Department Blue Cross and Blue Shield of Kansas City P.O. Box 417005 Kansas City, MO 64179-9773</p>
<p><b>Green Shield</b> (Canadian Health Plan)</p> <p>888-711-1119 <a href="http://www.greenshield.ca">http://www.greenshield.ca</a></p>	<p>Self-serve using your Plan Member Online Services Account</p> <p>Send an inquiry via <a href="http://www.greenshield.ca/en-ca/get-in-touch">www.greenshield.ca/en-ca/get-in-touch</a></p> <p>P.O. Box 1606 Windsor, ON N9A 6W1</p>	<p>P.O. Box 1606 Windsor, ON N9A 6W1 Attention: Supervisor “insert claim type” Department</p> <p><a href="mailto:Customer.service@greenshield.ca">Customer.service@greenshield.ca</a></p>
<p><b>Health Alliance Plan</b> (HMO)</p> <p>800-422-4641 (Commercial) 800-801-1770 (Medicare Advantage)</p> <p><a href="http://www.hap.org">http://www.hap.org</a></p>	<p>2850 W. Grand Blvd. Detroit, MI 48202 Attn: Claims</p>	<p>2850 W. Grand Blvd. Detroit, MI 48202 Attn: Manager of Grievance Department</p> <p>Members may also submit Appeals by fax to 313-664-5866 or in person at the HAP location at 2850 W. Grand Blvd. or at the HAP Troy location at 1414 E. Maple, Troy, MI 48083</p>

## Health Maintenance Organizations

Health Plan Carrier Name	Claim Inquiries	Appeals
<b>HealthPartners (HMO)</b> HMO: 952-883-5000 Medicare: 952-883-7979 or 1-800-233-9645 TTY 711 <a href="http://www.healthpartners.com">http://www.healthpartners.com</a>	Member Services HealthPartners P.O. Box 1309 Minneapolis, MN 55440-1309	Member Services HealthPartners P.O. Box 1309 Minneapolis, MN 55400-1309
<b>Humana (HMO)</b>  800-758-5002 <a href="http://www.humana.com">http://www.humana.com</a>	Humana Claims P.O. Box 14601 Lexington, KY 40512-4601	Grievance and Appeals P.O. Box 14546 Lexington, KY 40512-4546
<b>Kaiser Permanente Northern California (HMO)</b>  800-464-4000 <a href="http://www.kp.org">http://www.kp.org</a>	Kaiser Foundation Health Plan Claims and Referrals Member Services P.O. Box 12923 Oakland, CA 94604-2923 Phone: 800-390-3510	Member Services: 800-464-4000
<b>Kaiser Permanente Southern California (HMO)</b>  800-464-4000 <a href="http://www.kp.org">http://www.kp.org</a>	Kaiser Foundation Health Plan Claims and Referrals Member Services P.O. Box 7004 Downey, CA 90242-7004 Phone: 800-390-3510	Member Services: 800-464-4000
<b>Kaiser Permanente Northwest (HMO)</b>  800-813-2000 <a href="http://www.kp.org">http://www.kp.org</a>	Kaiser Foundation Health Plan of the Northwest Member Relations Department 500 NE Multnomah St. Suite 100 Portland, OR 97232-2099	Kaiser Foundation Health Plan of the Northwest Member Relations Department 500 NE Multnomah St. Suite 100 Portland, OR 97232-2099
<b>Kaiser Permanente Georgia (HMO)</b>  404-261-2590 or 888-865-5813 <a href="http://www.kp.org">http://www.kp.org</a>	Kaiser Permanente Claims Administration P.O. Box 190849 Atlanta, GA 31119-0849	Kaiser Permanente Appeals Department Nine Piedmont Center 3495 Piedmont Road, N.E. Atlanta, GA 30305-1736
<b>Kaiser Permanente Colorado (HMO)</b>  303-338-3800 <a href="http://www.kp.org">http://www.kp.org</a>	Kaiser Permanente Claims Department P.O. Box 373150 Denver, CO 80237-3150	Kaiser Permanente Appeals Program P.O. Box 378066 Denver, CO 80237-8066
<b>Kaiser Permanente Mid-Atlantic (HMO)</b>  301-468-6000 [DC Area] 800-777-7902 <a href="http://www.kp.org">www.kp.org</a>	Kaiser Permanente Claims P.O. Box 6233 Rockville, MD 20849-6233	Kaiser Permanente 2101 E. Jefferson St. Rockville, MD 20852 Fax: 301-816-6733

**UAW RETIREE**  
**Medical Benefits Trust**

The logo features the text "UAW RETIREE" in a bold, sans-serif font above "Medical Benefits Trust" in a serif font. A white circular arc is positioned to the right of the text, partially overlapping the word "Trust".

**Retiree Health Care Connect 866-637-7555**  
**[www.uawtrust.org](http://www.uawtrust.org)**