UAW RETIREE
Medical Benefits Trust

Summary Plan Description
2023

Retiree Health Care Connect 866-637-7555
www.uawtrust.org

WELCOME AND INTRODUCTION

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, 2023, 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 this SPD, the Plan Document, Schedule of Benefits, the Benefit Highlights Letter(s), 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. A Health Care Benefit Summary that describes all the benefits that changed since this SPD was issued will be available to new Members enrolling in the Plan. You should carefully read the Benefit Highlights Letter and the Health Care Benefit Summary when it arrives. 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 Letter(s), Health Care Benefit Summaries, 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 a Health Maintenance Organization (HMO), an HMO Medicare Advantage plan, or a Medicare Advantage Prescription Drug plan (HMO or Preferred Provider Organization (PPO)), 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

This SPD has been designed to be as readable as possible. If a word begins with a capital letter, then it is usually defined in the Definitions Section of this SPD, which is near the end of this SPD. At times, the language will be technical or legalistic, but that language is there because of certain requirements.

As you read through this SPD, you will notice that certain sections are marked 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

866-637-7555

Enrollees can get answers to their questions by calling Retiree Health Care Connect. Retiree Health Care Connect represents the Plan and can either answer Your questions or redirect You to where You can get answers.

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 as soon as possible after they happen. Retiree Health Care Connect can advise You as to how, if at all, that event changes eligibility for You and/or Your Dependents. See the Chapter on Eligibility and Enrollment 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 uawtrust.org. Also on the website, You will have the ability to access the websites for Retiree Health Care Connect and the Carriers, 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
Welcome Kit	Within 90 days of retirement or enrollment in the Plan	Packet of information about Your Plan 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
Notice of Minimum Essential Coverage (for non-Medicare members)	January-February	IRS-required notification that Your Plan medical coverage meets minimum requirements	Have it in-hand when You are filling out Your federal income taxes
Notice of New Plan	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, consider which plan is best for You and call Retiree Health Care Connect, if You decide to change plans
Benefit Highlights Letter	August-September	Statement of updates to the plans and applicable cost-sharing for the upcoming year	Read it carefully and store with Your SPD

Name of Communication	Usual Time Received	What It Is	What You Should Do with It
Annual Notice of Change/Evidence of Coverage (for Medicare members)	September-December	Statement of updates to Your Medicare Advantage, Medicare Advantage Prescription Drug, and/or Part D Prescription Drug plans, including new cost-sharing or new service limits	Read it carefully and store with Your SPD
Status of Trust Letter	November-January	Description accompanying the Summary Annual Report that describes the progress and status of the Trust	Read it
Summary Annual Report	November-January	Department of Labor required summary of the Trust's financial status	Read it
General Enrollment Letters (members with Medicare Part A only)	December-February	Notification that you need to enroll in Medicare Part B	Read it and enroll in Medicare Part B
Miscellaneous Notices			
Age-in to Medicare Letter (for members turning 65 years old)	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
Age 19-26 Dependent Audit (members with Dependent Children aged 19-26)	August-September	Verification of dependent eligibility under Plan rules	Read it and respond
Health Notice Discussing a Particular Benefit or Condition	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
Notice of Privacy Practices	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

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I. ELIGIBILITY AND ENROLLMENT

A. GENERAL ELIGIBILITY INFORMATION

A Retiree begins participating in the Plan upon their enrollment in a health plan offered under this Plan. A Dependent, such as a Spouse, Same-Sex Domestic Partner, or child, may be eligible to participate in a health plan offered under the Plan because of their relationship with the Primary Enrollee.

In order to participate in the Plan, all Retirees and Dependents must be enrolled in Medicare Part A when first eligible, unless first eligible before January 1, 2017. If residing in the U.S., a Medicare-eligible Retiree and Dependent must be present lawfully.

B. 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 uawtrust.org.

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.

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.
- Do not enroll (voluntarily or automatically) in Medicare Part A when first eligible, if You first became eligible on or after January 1, 2017; or
- Are present in the U.S. illegally (i.e., are not a U.S. citizen, do not have a legal visa, or do not have other government-approved documents giving You legal status in the U.S.) while otherwise eligible for Medicare but for lack of lawful presence in the U.S.

Primary Enrollees fit within one of two categories: "Protected" or "General". These categories relate to certain differences in cost-sharing and Contributions. If a Primary Enrollee is "Protected" so are his or her Dependents.

A Primary Enrollee and/or his or her Dependent fits within the "General" category when he or she does 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.

If a Retiree and their Spouse each qualify as a Primary Enrollee under the Plan, they may choose to enroll in different health plans. Each Retiree is eligible to be both the Primary Enrollee in one health plan and also at the same time be a Spouse in another health plan.

C. 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.

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 Company plan at the time of Your retirement are eligible for coverage under the Plan, if 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 dependent child of Your Same-Sex Domestic Partner after You retire.

In order to be eligible for coverage under the Plan, Your Same-Sex Domestic Partner must:

- Be the same sex as Your current sex;
- Have shared a continuous, committed, romantic relationship with You for at least six months, intend to do so indefinitely, and have no such relationship with another person;
- Be jointly responsible for Your welfare and financial obligations, and likewise You must be jointly responsible for his or her welfare and financial obligations;
- Reside in the same household as You;

- Not be related to You by blood to a degree of kinship that would prevent Your marriage to that Same-Sex Domestic Partner from being recognized under Internal Revenue Service rules;
- Have reached age 18 and be legally competent to enter into a contract; and
- Not be married to a third party.

In order to be eligible for coverage under the Plan, the 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 or active employee of an Auto Company, Your surviving Spouse, surviving Same-Sex Domestic Partner, and surviving Dependent Children may be eligible for coverage.

To be eligible for coverage, a surviving Spouse or surviving Dependent Child 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 on the date of the Auto Company employee's death and the Auto Company employee was eligible to retire on the date of death;
- If eligible, be enrolled in Medicare Parts A and B; and
- Pay the required Contribution.

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.

The following survivors are not eligible for coverage under the Plan:

- Survivors of a Retiree who was eligible only for a deferred vested pension benefit;
- Survivors eligible only for a pre-retirement survivor benefit under the Auto Company's pension plan; or
- Survivors eligible for receipt of pension benefits as "alternate payees" under a qualified domestic relations order pursuant to the Retirement Equity Act of 1984.

A Spouse or Same-Sex Domestic Partner who becomes a surviving Spouse or surviving Same-Sex Domestic Partner must enroll in Medicare Parts A and B when eligible in order to be eligible for coverage under the Plan. If a surviving Spouse or surviving Same-Sex Domestic Partner do not enroll in both Medicare Parts A and B as described above, they will lose their coverage under the Plan. Coverage for survivors without Medicare Parts A and B can be reinstated as of the Medicare Parts A and B effective date.

Surviving Spouses and surviving Same-Sex Domestic Partners may not add a new Spouse or Same-Sex Domestic Partner under the Plan. A surviving Spouse/surviving Same-Sex Domestic Partner may enroll a Dependent Child in the Plan only if the Dependent Child was eligible to be enrolled on the Retiree's date of death. A surviving Spouse/surviving 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.

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/surviving 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 by Retiree Health Care Connect.

4. *Eligibility for Dependent Children*

Retirees may add children as Dependents under the Plan if they meet all of the following five eligibility tests. However, for a biological or adopted child, if the Primary Enrollee's divorce decree says the Primary Enrollee does not have custody of the Dependent Child but is legally responsible for health care expenses or for providing health care coverage, then the dependency and residency eligibility tests below are met, and the child is eligible for coverage as a Dependent Child under the Plan. An individual that could be considered a Dependent of more than one Primary Enrollee may be enrolled as a Dependent by each such Primary Enrollee.

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;

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.

- 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
- A child by legal guardianship or under a custody order. 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 that 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 Dependent Children 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 by the Plan 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 Child is determined to be permanently and totally disabled if he or she has a medically determinable physical or mental condition that prevents him or her 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 as a permanently and totally disabled Dependent Child, the Dependent Child 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.

D. 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 after deferring enrollment, coverage under the Plan will begin on the first day of the month following the later of: (a) notification to Retiree Health Care Connect; and (b) after You submit all required proof (see Sub-section E below). Failure to enroll a Dependent when the Dependent is first eligible for coverage will be treated as deferring enrollment for the Dependent.

2. *Enrolling a New Dependent*

Call RHCC at 866-637-7555

You should contact Retiree Health Care Connect to add Your new Dependent within 30 days from the date of the event that makes them eligible for coverage under the Plan (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 more than 30 days after the date of the event, coverage will begin on the first day of the month following the date You notify Retiree Health Care Connect of the event. 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 answer any questions You may have about Your coverage under the Plan.

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. If the Plan pays any claims on behalf of any individual who was not eligible for benefits, You will have to repay the Plan for all of those claims. The Plan will not be responsible for these claims

5. *Reinstatement*

There are certain rules the Plan has to follow regarding retroactive reinstatement into Medicare Advantage, Medicare Advantage Prescription Drug and Medicare Part D plans. So, if You disenroll from one of these plans and then are reinstated, the Plan may have to enroll You in a different plan temporarily.

a. *Reinstating a Dependent*

If a Dependent loses eligibility and later becomes eligible again (for example, a Dependent Child moving out of the Retiree's home and moving back into 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 date the Primary Enrollee notifies Retiree Health Care Connect requesting the reinstatement and applicable eligibility tests are met.

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 Contributions. At the time of reinstatement, the Primary Enrollee may be required to 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 Contributions, coverage can be reinstated the first day of the month after You call Retiree Health Care Connect and reenroll, but You will have no coverage for any services received while You did not make Contributions. There are certain rules the Plan has to follow regarding retroactive reinstatement into Medicare Advantage, Medicare Advantage Prescription Drug, and Medicare Part D plans. So, if You are enrolled in one of these plans, are terminated for non-payment, and then reinstated, the Plan may have to enroll You in a different plan temporarily.

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

If You 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. If You are the Primary Enrollee and fail to enroll in Medicare Part A when You first become eligible, the Plan will also terminate the coverage for Your Dependents. If You then enroll in Medicare Part A, Your coverage can be reinstated the first day of the month after the Plan receives confirmation from Medicare of Your enrollment and you call Retiree Health Care Connect to request reinstatement. Note that a failure to timely enroll in Medicare Part A when You are first eligible could result in You being charged a late enrollment penalty.

d. *Reinstatement after Termination for Unlawful Presence*

If Your coverage is terminated by the Plan because You reside in the U.S. illegally (for example, You were not a U.S. citizen or were not on a valid visa) while otherwise eligible for Medicare but for lack of lawful presence in the U.S., You can be reinstated the first day of the month after You provide proof of Your legal residency in the United States A similar reinstatement is available for a termination of 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 Retiree Health Care Connect to have Your coverage reinstated. That coverage will be effective the first day of the month after You notify Retiree Health Care Connect.

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 reinstated back to that date, You must still provide the required information and You also must pay any Contributions. You may also be required to pay any applicable cost-sharing You owe for claims we pay on Your behalf.

g. *Unforeseen Circumstances*

If You believe that You were incorrectly denied enrollment at initial eligibility, You can make a claim for enrollment with the Trust. With other denials of enrollment (such as following a reinstatement request), You should file a claim for enrollment with the Plan. If You believe You or Your Dependent are still denied coverage incorrectly, You can appeal that determination using the Appeals Procedures in the appropriate section later in this book.

E. 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.

F. COVERAGE STARTS AND STOP DATES

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

	Coverage Begins	Coverage Stops*†
Retiree	On Your retirement date	• The last day of the month of Retiree's death if Dependents are enrolled • The last day of the month for which the last Contribution was made • The last day of the second month after the month in which the Retiree does not enroll in Medicare Part A when eligible • The last day of the month in which Retiree is present unlawfully in the U.S. while otherwise eligible for Medicare but for lack of lawful presence in the U.S.
Spouse	• On the date the Retiree's coverage begins; • On the date that the Retiree marries the Spouse, if the marriage is reported to Retiree Health Care Connect within 30 days of marriage; or • On the first day of the month following the date of notice, if the marriage reported to Retiree Health Care Connect more than 30 days after the marriage.	• The date of a final decree of divorce from the Retiree • The last day of the month for which the last Contribution was made • The last day of the second month after the month in which the Retiree or Spouse does not enroll in Medicare Part A when eligible

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

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

	Coverage Begins	Coverage Stops*†
Spouse	(See page 9)	• The last day of the month in which the Retiree or Spouse is present unlawfully in the U.S. while otherwise eligible for Medicare but for lack of lawful presence in the U.S. • The last day of the month of the Retiree's death • Spouse's death
Child(ren) of Same-Sex Domestic Partners	• On the date the Retiree's coverage began, if the Child of the Same-Sex Domestic Partner was covered under the active Auto Company plan before retirement. • In the case of the Retiree's death and if the Child of the Same-Sex Domestic Partner was eligible to be enrolled by the deceased Retiree on the Retiree's date of death, coverage begins the first day of the month following enrollment.	• The date on which the Same-Sex Domestic Partner relationship with the Retiree or eligibility under the Plan ends • The last day of the month for which the last Contribution was made • The last day of the second month after the month in which the Retiree, Same-Sex Domestic Partner, or Same-Sex Domestic Partner's Child(ren) do not enroll in Medicare Part A when eligible • The last day of the month in which the Retiree, Same-Sex Domestic Partner, or Same-Sex Domestic Partner's Child(ren) are present unlawfully in the U.S. while otherwise eligible for Medicare but for lack of lawful presence in the U.S. • The date the Child of the Same-Sex Domestic Partner is removed from coverage under the Plan • Same-Sex Domestic Partner's death • Same-Sex Domestic Partner's Child's death

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

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

	Coverage Begins	Coverage Stops*†
Dependent Children	• On the date the Retiree's coverage begins; • On the date the Dependent is acquired, if reported within 30 days of event; or • If later than 30 days after the event, the first of the month following the date of notice.	• When the Dependent no longer meets the Plan's eligibility rules • The date the Dependent is removed from coverage by the Primary Enrollee • The end of the month for which the last payment was made • The date of the contract under which the Dependent was covered ends • The end of the second month after the month where Retiree or Dependent Child does not enroll in Medicare Part A when eligible • The end of the month where Retiree or Dependent Child is present unlawfully in the U.S. while eligible for Medicare • Dependent Child's death
Surviving Spouse or Surviving Same-Sex Domestic Partner	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 the Retiree's death	• The date of death of the Surviving Spouse or Surviving Same-Sex Domestic Partner • The last day of the month for which the last Contribution was made • The last day 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 • The last day of the month where Retiree or Dependent Child is present unlawfully in the U.S. when otherwise eligible for Medicare but for lack of lawful presence in the U.S.

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

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

G. 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.

H. TERMINATION FOR NON-PAYMENT OF CONTRIBUTION

If You do not pay Your Contribution on time 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 on time, 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.

I. TERMINATION FOR FRAUD

If You or Your Dependents commit fraud or deliberately make misleading statements to the Plan or the Carrier, 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 or Carrier pays because of fraud will become Your responsibility to pay.

J. 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 before January 1, 2017; or
- If You (or Your Dependent) become eligible for Medicare on the basis of having End-Stage Renal Disease.

K. TERMINATION FOR UNLAWFUL PRESENCE

If You or Your Dependents become eligible for Medicare or otherwise eligible for Medicare but for lack of lawful presence in the U.S. 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 SPD for information about how You can reinstate Your coverage if Your residency in the U.S. becomes legal.

II. HEALTH PLAN OPTIONS

If You are enrolled in the ECP, TCN, Humana Commercial, Dental, Vision, Hearing, or Over-the-Counter Benefit plan, Your benefits will be described in more detail in this SPD. If You select an HMO, MA HMO, or MA-PD (PPO or HMO) 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 the health plan options offered by the Plan.

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 to non-Medicare members, 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 You to receive services from In-Network Providers and Out-of-Network Providers.

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

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. For non-Medical Emergencies, You should find out whether the service, device, treatment, or other item is covered before receiving the service.

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 and participate in its network 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 even if You are responsible for paying it.

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 doctor 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 In-Network Providers. Non-Medical Emergency and non-urgent care services obtained from Out-of-Network Providers are NOT covered at all unless the HMO preauthorizes treatment. Emergency services and urgent care provided by Out-of-Network Providers 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 enroll in Medicare, You will be placed into the Medicare Advantage or Medicare Advantage Prescription Drug plan associated with Your current HMO. For more information about the HMO option(s) in Your specific geographic area, contact Retiree Health Care Connect.

3. Humana Commercial

The Humana Commercial plan 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. The Humana Commercial plan is only offered in a limited area and to certain Enrollees. This plan provides 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 Humana Commercial plan, and that doctor or facility coordinates all Your health care needs.

The scope and level of benefits and coverage provided by the Humana Commercial plan may differ from other plan options contracted with the Plan.

In order for services to be covered by the Humana Commercial Plan, You must receive the services from In-Network Providers. Non-Medical Emergency and non-urgent care services obtained from Out-of-Network Providers are NOT covered at all unless the Carrier preauthorizes treatment. Emergency services and urgent care provided by Out-of-Network Providers are covered (subject to the Humana Commercial plan's rules).

B. PLAN OPTIONS FOR MEDICARE ENROLLEES

1. 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 to Plan members enrolled in Medicare, 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 enrolled in this plan, Medicare is primary and TCN coverage is secondary to original Medicare. This option allows You to receive services from both In-Network Providers and Out-of-Network Providers.

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 an In-Network Provider. 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. If You choose to receive care from an Out-of-Network Provider who does not accept Medicare, You will likely be responsible for 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 even if You have to pay it.

If You choose to receive care from an Out-of-Network Provider who does not participate in TCN, You will be responsible for additional costs unless the service is for Medical Emergency care.

2. Medicare Advantage Prescription Drug Option

Medicare Advantage Prescription Drug (MA-PD) Plans are health plan options approved by Medicare and administered by private companies (Carriers). They are different from Medicare Advantage plans because in addition to providing all of Your Medicare Part A (Hospital) and Part B (medical) benefits, MA-PD plans also provide all of Your Part D (prescription drug) benefits.

MA-PD 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 Parts A and B and if You or Your Dependent: (a) do not have MA coverage; (b) do not have Medicare Part D prescription drug coverage outside the Plan; and (c) are not Protected, the Plan will inform You that You or Your Dependent will be automatically enrolled into an MA-PD plan. This automatic enrollment will be effective on January 1st of the year following the date You or Your Dependent enroll in Medicare Parts A and B. You or Your Dependent 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-PD plan, members must be enrolled in Medicare Parts A and B. If You wish to enroll in an MA-PD plan prior to the end of the year in which You enroll in Medicare Parts A and B, You may do so by calling Retiree Health Care Connect. Whether an MA-PD plan is available to You and, if so, which MA-PD plan(s) are available to You under the Plan, depends on where You live, Your Medicare status, and other factors. For more information about the MA-PD option(s) in Your specific geographic area, contact Retiree Health Care Connect. While enrolled in an MA-PD plan, You must continue to pay Your Medicare Parts A (if required) and B premiums. However, MA-PD Plans may have different Contributions, Deductibles, Copayments, and Coinsurance than other available options.

Also, MA-PD 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). MA-PD (HMO) Plans have provider networks, so if You are enrolled in one of these plans, You will be required to see In-Network Providers and use specific Hospitals.

3. Medicare Advantage Option

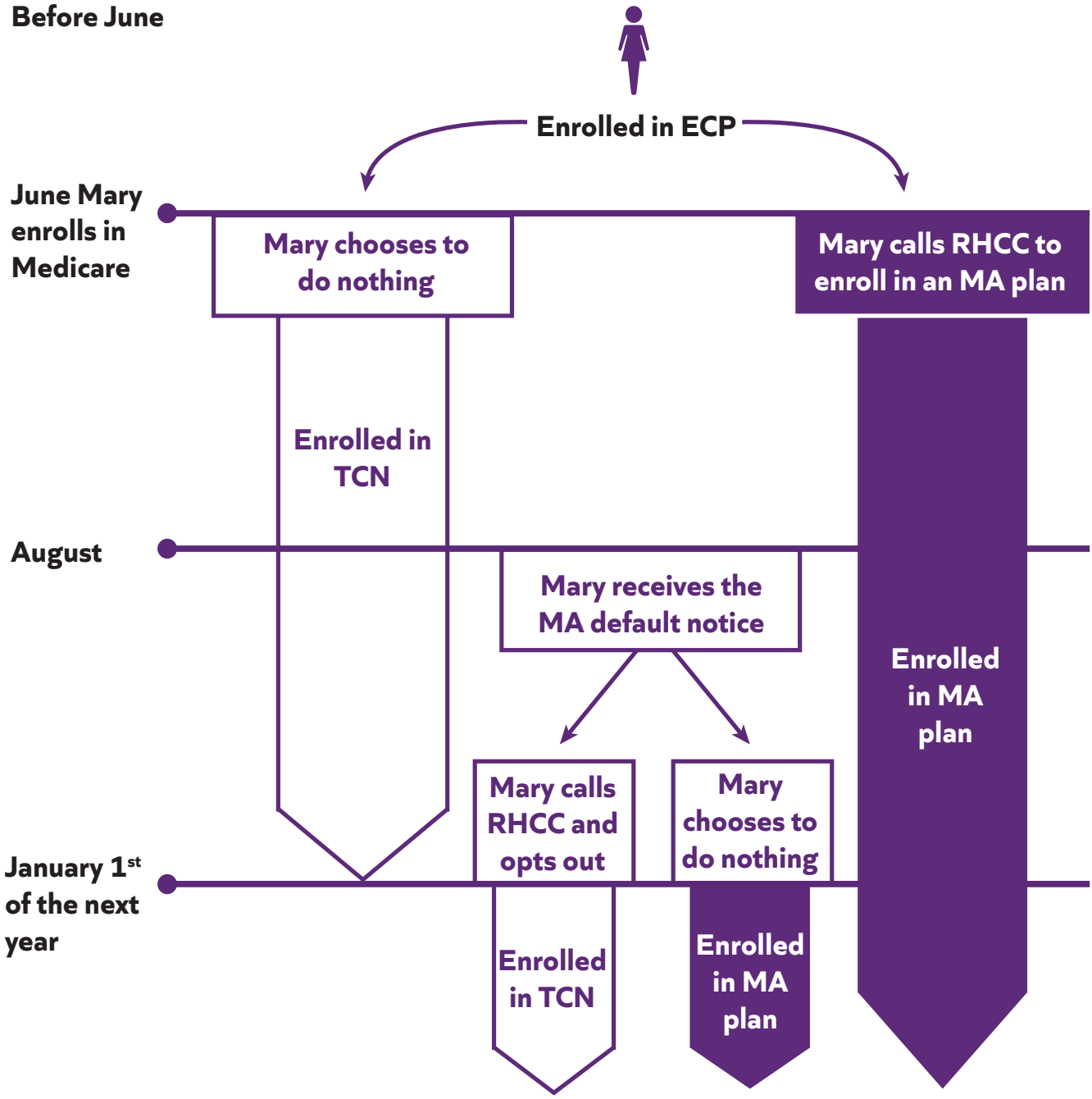
Medicare Advantage (MA) Plans are health plan options approved by Medicare and administered by private companies (Carriers). MA Plans provide all of Your Medicare Part A (hospital) and Part B (medical) benefits.

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 enroll in Medicare Parts A and B, 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 Contributions, 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 (HMO) have provider networks, so if You are enrolled in one of these plans, You will be required to see In-Network Providers and use specific Hospitals.

4. Illustrative Example on Medicare Enrollment

Mary is enrolled in the ECP plan until she turns 65 and enrolls in Medicare Parts A and B effective 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 Prescription Drug (MA-PD) 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 in which she turns 65 and enrolls in Medicare Parts A and B, Mary will receive notice that she will be enrolled into an MA-PD 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-PD plan beginning January 1st.


Before June
Enrolled in ECP
June Mary enrolls in Medicare
Mary chooses to do nothing
Mary calls RHCC to enroll in an MA plan
Enrolled in TCN
August
Mary receives the MA default notice
Enrolled in MA plan
Mary calls RHCC and opts out
Mary chooses to do nothing
January 1st of the next year
Enrolled in TCN
Enrolled in MA plan

C. PLAN OPTION RULES FOR NON-MEDICARE AND MEDICARE ENROLLEES

1. Prescription Drug Coverage

Prescription drug coverage may or may not be included in the coverage provided by the medical plan and Carrier selected. If prescription drug coverage is not included in the medical plan and Carrier selected, the Plan will automatically enroll You and Your Dependents in prescription drug coverage.

2. Dental

The Dental Plan offered by the Plan has two levels of In-Network Providers, with one level of those In-Network Providers having lower cost sharing, and also Out-of-Network Providers (generally at a higher cost sharing).

3. Vision

The Vision Plan offered by the Plan has In-Network Providers (generally at a lower cost sharing) and Out-of-Network Providers (generally at a higher cost sharing).

4. Hearing

All covered Hearing Plan services must be provided by an In-Network Provider.

5. Over-the-Counter Benefit

Note: this benefit is not available for the non-Medicare HMO plans or the Humana Commercial plan.

This benefit provides an annual allowance that may be used to purchase eligible over-the-counter drugs and non-prescription healthcare items.

D. PLAN OPTION RULES

1. Rolling Enrollment – Changing Your Plan Option Election

You may change Your Plan elections at any time of the year, if 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 will usually take effect on the first day of the second month following the month Retiree Health Care Connect receives Your election change (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). You may be allowed to

make a change to Your Plan elections sooner if You have certain life events happen (like a permanent address change, adding or removing a Dependent from coverage, or becoming Medicare eligible) or if a new plan option becomes available in the area where You live.

If You are enrolled in an MA, or MA-PD plan option, You may disenroll from the plan option at any time. The disenrollment will be effective the first day of the month following the month when You notify Retiree Health Care Connect that You want to disenroll. After You disenroll from an MA or MA-PD plan option, the Plan will enroll You into the TCN plan or another plan option You select, if You are eligible for such plan option. If You disenroll from a MA or MA-PD plan and enroll into another plan option mid-year, Your Deductible and/or Your other cost sharing accumulators may reset back to $0 under the new plan option.

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

Households consisting of individuals enrolled in a Medicare plan option and others who are not enrolled in a Medicare plan option (known as a "Split Family") are allowed to split medical plan elections between available Medicare and non-Medicare plan options. For example, when You or one of Your Dependents becomes eligible for Medicare, that individual (the one enrolled in Medicare) will be offered Medicare plan options under the Plan. The remainder of Your household may continue to be enrolled in their current non-Medicare plan option.

When all individuals in a household are eligible to enroll in a Medicare plan option (or all not eligible to enroll in a Medicare plan option), 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 aged 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 unless You were first eligible for Part A before January 1, 2017. Canceling 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 some 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.

Some people need to contact the Social Security Administration to enroll in Medicare Part B, but some people 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 after Your birthday) 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 may 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 to report Your situation.

Generally, You and Your Medicare-eligible Dependents must enroll in Medicare Part A when first eligible.

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.

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%. 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% 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 canceled 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 eligible. If You are eligible for and/or entitled to Medicare and were not eligible before January 1, 2017, 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 when first eligible.

The Plan provides outpatient prescription drug benefits to Retirees and Dependents who are eligible for Medicare under a Trust-specific Medicare Part D Prescription Drug plan, explained more fully in Section V. However, if You or Your Dependents enroll in a Medicare

Part D Prescription Drug Plan that is not offered under the Plan, Your prescription drug benefits under the Plan will be terminated.

If an individual is enrolled in Medicare and also enrolled in the Plan, the Plan will reduce the amount it pays so that the total benefits payable under this Plan and the amounts paid under Medicare Parts A, B, C, and/or D do not exceed the total Allowed Amount. If an individual is eligible to enroll in but is not enrolled in Medicare Part A and was not eligible before January 1, 2017, the individual is not eligible for coverage under the Plan. If an Enrollee is eligible to enroll in but is not enrolled in Medicare Part B, the Plan will reduce the amount it pays to equal the amount the Plan would have paid if the member was enrolled in Medicare Part B.

IV. COVERAGE WHEN YOU HAVE MEDICARE

The Plan enhances your coverage under Medicare when You are enrolled in the Traditional Care Network (TCN) plan. The TCN plan covers most benefits that Medicare Parts A and B cover. After Medicare pays its share for covered benefits, the TCN plan will generally cover the balance of the cost of those covered services. You will be responsible for the applicable Deductible, Coinsurance, and Copayments associated with the Plan.

NOTE: If You are enrolled in a MA or MA-PD 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 plan works with Medicare.

A. MEDICARE COST SHARING FEATURES

Medicare Parts A and Part B require 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 have to pay a Part B annual deductible before Medicare pays anything toward Your health care services (with certain limited exceptions).

If You have questions regarding Your Medicare Parts A or B 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 and Your Dependents are required to enroll in Medicare Part A when You are first eligible, unless first eligible before January 1, 2017. If You do not, the Plan will terminate Your coverage the last day of the seven-month period in which You were eligible to enroll in Medicare Part A but failed to do so. For example, if You turn 65 in April, Your seven-month Medicare Part A enrollment period starts January 1st and ends July 31st. So, if You do not enroll in Medicare by July 31st, then the Plan will terminate Your coverage July 31st.

If You enroll in Medicare Part A after such a termination and contact Retiree Health Care Connect to let us know when You enrolled, Plan coverage will restart the first day of the month after the Plan receives confirmation from Medicare that You are enrolled in Medicare Part A. Dependents whose coverage is terminated under the Plan because the Primary Enrollee lost Medicare Part A coverage may be reinstated the first day of the month after the Plan receives confirmation from Medicare that the Primary Enrollee is enrolled in Medicare Part A.

You SHOULD enroll in Medicare Part B as soon as You are eligible.

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.

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 Medicare Part B, but not enrolled in Medicare Part B, You will have significantly higher out-of-pocket medical expenses under the Plan.

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 both Medicare Parts A and Part B when first eligible.

The Plan will terminate coverage for surviving Spouses/surviving Same-Sex Domestic Partners if they are eligible, but not enrolled in, Medicare Parts A and B. If a surviving Spouse or surviving Same-Sex Domestic Partner enrolls in Medicare Parts A and B after such a termination and contacts Retiree Health Care Connect to enroll under the Plan, Plan coverage will generally restart the first day of the month following the date You contact Retiree Health Care Connect to enroll under the Plan. The Plan requires confirmation from Medicare that enrollment in Medicare Parts A and B has occurred before it will restart coverage.

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.

If You are eligible for Medicare Parts A and B, the Plan will process Your health care claims as if You are enrolled in Medicare and used Medicare Providers. If You are not enrolled in 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 because You have been diagnosed with 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:

Medicare allowed amount	**$1000**
Less Medicare Part B deductible*	**-233**
Medicare pays 80%	**-613.60**
Medicare coinsurance (20%)	**153.40**
Total amount not paid by Medicare ($233 Medicare Part B deductible plus $153.40 Medicare coinsurance)	**$386.40**

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

Medicare allowed amount	**$1000**
Amount Medicare paid	**-613.60**
Amount not paid by Medicare ($233 Medicare Part B deductible + $153.40 Medicare coinsurance)	**386.40**
Less the Plan Deductible [Paid by George]	**-386.40**
Balance	**0**

Less the 10% in-network Plan Coinsurance [Paid by George]	**-0**
Trust secondary payment amount [Paid by the Plan]	**0**
Total payment for services (Medicare + Plan)	**613.60**
George's Total Payment (Plan Deductible + Coinsurance)	**$386.40**

**This is only an example. Actual deductibles vary from year-to-year*

In this example, Medicare paid a total benefit of $613.60. George paid the remainder, which counted against his Plan Deductible. Once George meets his Plan Deductible and any cost-sharing, the Plan will pay the difference for covered services.

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

Medicare allowed amount	**$1000**
Less Medicare Part B deductible (Previously Met)	**-0**
Balance	**1000**
Medicare pays 80%	**-800**
Total amount not paid by Medicare ($200 Medicare coinsurance)	**$200**

**This is only an example. Actual deductibles vary from year-to-year*

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

Medicare allowed amount	**$1000**
Amount Medicare paid	**-800**
Amount not paid by Medicare	**200**
Less Plan deductible (Previously Met)	**-0**
Balance due for services	**200**
Less the 10% in-network Plan Coinsurance [Paid by George]	**-20**
Plan secondary payment amount [Paid by the Plan]	**180**
Total payment for services (Medicare $800 plus Plan $180)	**980**
George's Total Payment (Coinsurance)	**$20**

**This is only an example. Actual deductibles vary from year-to-year*

In this example, Medicare and the Plan paid total benefits of $980.

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 Provider accepts 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 these Providers require their patients to submit the claims to Medicare on their own, as well as potentially charge the patients up to 15% above the Medicare allowed amount, which Medicare will not pay. The Plan will not cover this 15% either, but the Plan 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 services from 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 doctors, laboratories, and other 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 current 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 after the Medicare Part B deductible is met. 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 UNDER MEDICARE

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 health care professional. The Plan covers Medically Necessary stays at In-Network and Out-of-Network SNFs. Following a three-day inpatient admission to a hospital, Medicare and the Plan will cover Your stay in an In-Network or Out-of-Network SNF for rehabilitation and further therapy. When the Plan covers Your In-Network or Out-of-Network SNF stay, the Plan will cover the portion not paid by Medicare, less Your applicable Deductible and Coinsurance up to Your Out-of-Pocket Maximum. The Plan coverage is different for In-Network SNFs and Out-of-Network SNFs.

In-Network SNF Benefits

Starting on the first day of your SNF stay that follows a three-day inpatient admission to a hospital and through your date of discharge, the Plan will cover the portion not paid by Medicare, as described under Section IV(H) Skilled Nursing Facility Stays. The Plan will continue to cover stays in a SNF if you are discharged and readmitted to the SNF at any time during the calendar year.

The 100-covered day limit and the 60-day break between SNF stays, which apply to Out-of-Network SNF stays and are described immediately below, do not apply to In-Network SNF stays.

Out-of-Network SNF Benefits

This benefit per covered SNF stay is limited to 100 covered days under both Medicare Part A and the Plan.

After an initial Out-of-Network SNF stay, both the Plan and Medicare require that You stop receiving SNF services for a period of 60 days before further SNF benefits are covered. If You require additional SNF days after those 60 days, the Plan will cover your SNF stay if this stay follows a three-day inpatient admission to a hospital (which is also required in order for your SNF stay to be covered by Medicare). The Plan will cover the portion not paid by Medicare as described under Section IV(H) Skilled Nursing Facility Stays.

You will also have coverage for another 100 days of Medically Necessary SNF care under the Plan at the beginning of each Plan Year, even if you have not stopped receiving SNF services for a period of 60 days.

I. EYE CARE UNDER MEDICARE

The Plan offers routine and diagnostic vision care. The Plan may cover routine and diagnostic vision services that Medicare does not. 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 for example:

- 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 people 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.

Vision benefits are described in more detail later in this SPD. 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 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 Provider must provide a written order for training offered by certified diabetic educators. The Plan will cover Your portion of the coinsurance under 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 Medicare 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 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 may require Case Management participation for certain conditions that are complex, severe, or rare.

If an Enrollee 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 covered 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, 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

Coverage, up to the Medicare Allowed Amount, is provided for Medically Necessary DME and P&O appliances prescribed by Your Provider. If 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. 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 are covered by Medicare and where You can find an approved Medicare supplier.

Coverage for DME and P&O is generally limited to only equipment and appliances covered by Medicare. However, the Plan covers some DME or P&O appliances that Medicare does not cover. Please contact Your Carrier to ask whether a specific piece of DME or P&O appliance is a covered benefit.

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 will need to get Your diabetic supplies under Medicare from an approved contracted supplier. Consult Section IV(J) of this SPD for more information on coverage of diabetes supplies.

You must use an approved Medicare supplier to receive DME coverage.

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

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 cover. Sometimes 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 Medical Benefits for ECP, TCN and Humana Commercial Enrollees Section of this SPD (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 Coverage."

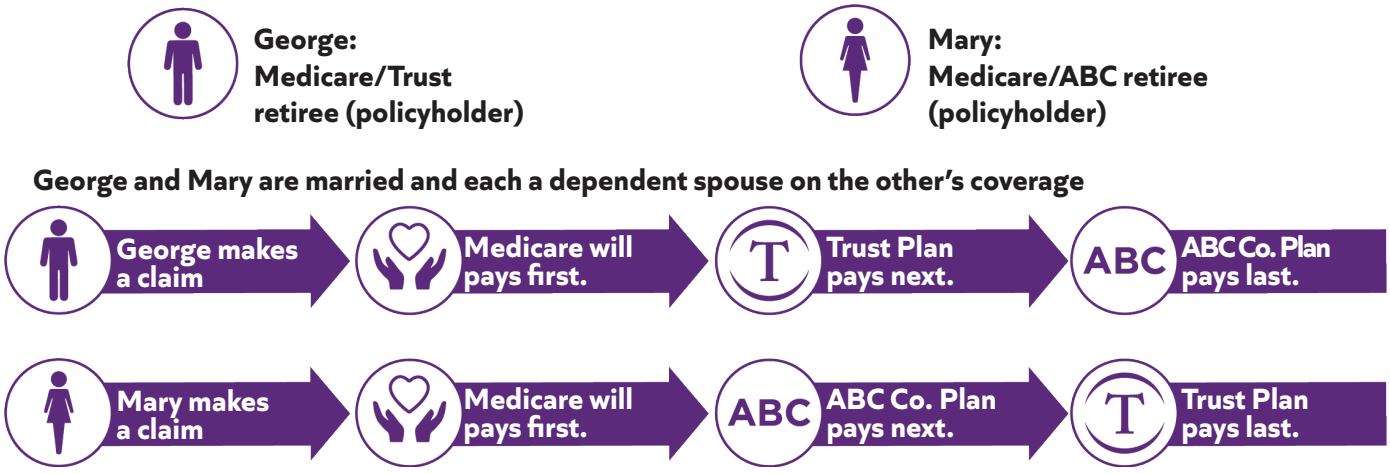
The Plan's benefits beyond Medicare are still coordinated with Medicare; they are not added to one another. For example, Medicare may not cover Your stay as an inpatient in the Hospital past the 90th day. The Plan's benefit will give You up to 365 days of care, but the Plan will have coordinated Your coverage with Medicare for the first 90 days, which would leave You with 275 days of covered inpatient Hospital stay under the Plan (365 days minus 90 days already covered by Medicare). During those first 90 days, the Plan is covering as secondary any costs not covered by Medicare, and You 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 receive services from a Provider that participates in Medicare, benefits paid by the Plan will be limited to an amount equal to the secondary balance payment that would have been paid if You received services from a Provider that participates in Medicare.

This chart may be helpful.



Unlike the chart above, where George is covered as a Dependent on Mary's ABC Co. retiree plan, You may be covered as a Dependent on Your Spouse's active employee health coverage as a Dependent. 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 on a medical claim under Medicare, You must follow Medicare's appeal process. 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 Benefits (EOB) statement that shows how both Medicare and the Plan paid the claim.

If You are appealing a benefit not covered by Medicare or for Plan eligibility, You should consult the Section X of this SPD.

V. PART D PLAN PRESCRIPTION DRUG COVERAGE

If You are enrolled in an MA HMO or the TCN plan, this section applies to You.

If You are enrolled in an MA-PD HMO or an MA-PD PPO plan, this section does not apply to You. You should consult Your MA-PD Evidence of Coverage for information about Your prescription drug benefits. You cannot be enrolled in an MA-PD plan and this Part D Prescription Drug plan at the same time.

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 (PBMs) or insurance companies, to administer the benefit on behalf of Medicare. These "Part D Plans" have to follow Medicare rules.

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 Your Dependents enrolled in Medicare. This plan is sometimes referred to as the Part D Employer/Union-Group Waiver Plan or "EGWP" (pronounced "egg-whip").

1. Automatic Enrollment into the Part D EGWP

If You do not have Part D prescription drug coverage outside the Plan, when You first enroll in Medicare Part A or Part B, the Plan will automatically enroll You into the Part D EGWP. This automatic enrollment will be effective the first day of the second month after the Plan is notified that You have enrolled in Medicare Part A or Part B. Before You are automatically enrolled in the Part D EGWP, You will be given an opportunity to "opt out." However, if You opt out of the Part D EGWP before enrollment or later choose to terminate Your enrollment in the Part D EGWP, You will not have any drug coverage under the Plan.

2. Opting Out of Automatic Enrollment into the Part D EGWP

If You "opt out" of the Plan's Part D EGWP, and do not enroll in a different Part D Plan right away, You will likely be responsible for a late enrollment penalty if You 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 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 Medicare Part D Prescription Drug Plan.

3. When You Are Enrolled in a Medicare Advantage Plan Option Offered by the Trust

You can be enrolled in a Medicare Advantage (MA) plan offered by the Trust with medical coverage only and the Plan's Part D EGWP. However, if You are enrolled in an MA plan offered by the Trust and You choose to enroll in an outside Part D plan (any Part D plan not offered to You by the Trust), You will be disenrolled from Your MA plan. We will automatically enroll You into the Traditional Care Network (TCN) plan, and You will have no drug coverage under the Plan. Please contact Retiree Health Care Connect if You have any questions about this aspect of Your prescription drug coverage.

4. If You Are Eligible for and Enrolled in Medicare but Your Dependents Are Not

If You are eligible for Medicare and are enrolled in Part A and B but Your Dependents are not eligible for Medicare, Your Dependents will receive prescription drug coverage under either the non-Medicare health plan in which they are enrolled (if their health plan includes prescription drug coverage) or the Plan will automatically enroll Your Dependents in non-Medicare prescription drug coverage.

5. More information on the Plan's Part D EGWP Prescription Drug Benefits

You can expect to receive a separate prescription drug card and a number of communications from the Part D EGWP 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 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, 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 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.

To determine if a particular drug is covered or not, You should look it up on the PBM's website or call the PBM. You can find the PBM's website and customer service phone number 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.

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

By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

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 doctor or pharmacist can assist You in substituting generic medications when appropriate. Generic drugs generally have a lower Copayment than brand name drugs. When a brand-name drug is dispensed instead of a generic equivalent version, You will be required to pay a higher Copayment. You are encouraged, where possible and appropriate, to ask Your Provider to prescribe generic drugs, which will be the lowest cost to You.

The Part D EGWP places drugs covered under the Formulary 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.

If Your doctor has not indicated "Dispense As Written" or DAW on Your prescription, it will automatically be filled with a generic drug. If You still request the brand-name drug and it is approved, You will pay a higher Copayment.

Biologic drugs and biosimilars are handled in a similar way as brand and generic drugs. 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.

E. WHERE TO GET PRESCRIPTIONS FILLED

The Part D EGWP 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.

1. Mail Order Pharmacy

Mail order allows You to fill up to a 90-day supply of prescription drugs You take on a regular, recurring basis. 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. You can expect to receive Your first filled prescription about two weeks from the time the PBM receives Your prescription. If You need a medication right away, make sure Your Provider gives You two prescriptions: one prescription for a 31-day supply for use at a retail pharmacy right away, and a second prescription for a 90-day supply to be sent to the mail order pharmacy. In this situation, Your 90-day supply prescription will be filled by the mail order pharmacy approximately three weeks after Your retail claim was processed. Refills can be ordered using the PBM's website, calling the PBM, using the PBM's mobile application, 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 Provider to the mail order pharmacy. The mail order pharmacy would then need to obtain Your permission to fill that prescription. If You have filled a drug through mail order within the past 12 months, the mail order pharmacy does not need Your permission to fill the prescription; the pharmacy will simply fill it and send You Your prescription. If the mail order pharmacy asks for Your permission to fill Your prescription, You should respond as quickly as possible, in order to avoid any delay in receiving Your prescription.

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 31-day supply. You should contact the PBM to determine which drugs are only available in a 31-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 network retail pharmacies across the country.

For 31-day supplies, particularly for prescriptions for controlled substances or prescriptions for which You and Your Provider are still trying to find the right strength, You are encouraged to use the retail pharmacy. The mail order pharmacy may not be allowed to fill certain prescriptions. You can choose to receive prescriptions for more than 31 days at a retail pharmacy, but it may cost You more.

3. Specialty Pharmacy

You may be prescribed a specialty medication. Specialty medications are injectable, infused, inhaled, or oral products with unique handling or dosing requirements. Many of these specialty medications are not available through a retail pharmacy but are available through a designated specialty pharmacy. In most situations, after You pay the required Copayment, the specialty pharmacy will ship the specialty drug and any required supplies You need directly to Your home. Specialty medications are generally limited to a 31-day supply.

F. PRESCRIPTION DRUG COPAYMENTS

Your prescription drug Copayment amount is based on which tier (level) it is on. These different tier levels are generally based on whether the drug is generic or brand name. The Copayment amount may be different whether You get the drug from 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 may pay for part of the Part D Copayment, leaving a lower Copayment for You to pay. If the discounted price of the prescription is lower than Your Copayment, You will be charged the lower amount.

Medicare Part D does not cover the entire cost of prescription drugs. The Plan pays for some of the cost of covered prescription drugs. 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 – Extra Help is a Medicare-approved program that can help You save on Medicare Part D prescription drug costs. As a Plan 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. UTILIZATION MANAGEMENT

The Plan has some limitations and requires authorizations on certain prescription drugs it covers.

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, if it is normally considered safe to take only one pill per day for a certain drug, the Plan may limit coverage for Your prescription to no more than one pill per day. These drugs are noted with "QL" in the Formulary.

2. Dose Duration Limits

For certain drugs, the Plan may cover only a specific dose of a drug over a specific period of time.

3. Dose Optimization/Tablet Consolidation

Sometimes the PBM will notify Your Provider of an opportunity to reduce the number of dosage units dispensed, while still fully satisfying Your therapeutic needs. For example, tablet consolidation means that You take one tablet of a higher strength daily rather than two tablets of a lower strength daily (same total daily dose).

4. Prior Authorization

The Part D EGWP requires a review by one of its pharmacists to determine if certain drugs qualify for coverage under the Plan. This is called Prior Authorization and sometimes called preapproval. For example, Prior Authorization may be used to confirm the diagnosis for which the drug is prescribed. If Your Provider prescribes a drug that requires Prior Authorization, the PBM will contact Your Provider to complete the Prior Authorization review. If Your Provider prescribes a drug for Off-Label Use, it may be covered if the use is supported by the major drug compendia or authoritative medical literature.

5. 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.

Each of these restrictions must be approved by Medicare, and several of them are required by Medicare for Part D plans.

H. PRESCRIPTION DRUG EXPENSE EXCLUSIONS

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

- Drugs not approved by the FDA;
- Drugs available over-the-counter without a prescription (exception example: 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) (note that treatment for gender dysphoria will not be considered a cosmetic purpose);
- Medical devices or appliances used in the dispensing of or in connection with prescription medication(s) (although these devices and appliances may be covered under Your medical plan). Please contact the Carrier for coverage information;
- Charges for more refills than Your doctor specifies or refills after a year from the original date of the prescription;
- Drugs used for treatment of sexual/erectile dysfunction or inadequacy;
- Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs, and minerals, whether they can be purchased over-the-counter or require a prescription (exception examples: foods and nutritional supplements provided during covered hospitalization and via intravenous care at home, prenatal vitamins, and vitamins or minerals requiring a prescription and used for treatment or prevention of a documented medical condition are covered);
- Naturopathic, naprapathic, or homeopathic services and substances;
- Drugs to enhance athletic performance, such as anabolic steroids;
- Certain dental products (please contact the PBM to determine if a particular dental product is covered);
- Cosmetic skin treatment products (exception: Retin-A and Accutane, which are payable to age 26 when Medically Necessary);
- Weight control drugs or anorexiants;
- Compounded prescriptions in which there is not at least one ingredient that is a Federal Legend Drug requiring a prescription, as defined by federal or state law; and
- Take-home drugs or medicines provided by a Hospital, emergency room, ambulatory surgical facility/center, Provider's office, or other health care facility.

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. MEDICAL BENEFITS FOR ECP, TCN AND HUMANA COMMERCIAL ENROLLEES

Generally, this section describes the medical benefits for all Enrollees in the Enhanced Care PPO (ECP), Traditional Care Network (TCN), and Humana Commercial plans. If a sub-section only applies to some and not all of the plans, it is noted below. This is a general description of benefits only. Some of the specific terms used in this section are defined under "Quick References" at the end of this SPD.

To get a complete understanding of Your benefits, it is important that You also review the Schedule of Benefits, Health Care Benefits Summary, and Benefit Highlights Letter. If You are enrolled in the TCN plan, it is important that You also review the Medicare website (https://www.medicare.gov/what-medicare-covers), since TCN covers most benefits that Medicare Parts A and B cover.

NOTE: If You are enrolled in an HMO, MA-PD HMO or PPO or a Medicare Advantage HMO, 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 Health Care Benefit Highlights 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 Dependents included on Your coverage. Once the Deductible is met, Coinsurance may apply for covered services or supplies You receive. 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 specific covered services or supplies after any applicable Deductible is met and until You reach the annual Out-of-Pocket Maximum. Such amount is calculated as a percentage of the Allowed Amount for each covered service or supply. For example, if the Coinsurance is 10% for a specific covered service, 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 covered 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.

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 or supplies for which You owe a Copayment (instead of Coinsurance) (e.g., office visits, urgent care visits)
- Services or supplies for which You do not get the required Prior Authorization
- Services or supplies denied by the Plan as Experimental or Investigational or not Medically Necessary
- Services or supplies not covered by the Plan

Cost-sharing that applies when a covered service is performed in person also applies to that covered service when it is approved to be performed remotely, unless otherwise noted.

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 on or after the effective date of coverage for Enrollees. Coverage is only for the period that is Medically Necessary for the proper care and treatment of the Enrollee and is sometimes limited to a certain number of days as discussed below. Coverage is also sometimes limited by other Plan rules. As a condition of coverage, the Carrier may require Prior Authorization of the admission.

1. Inpatient Hospital Coverage

Most services You receive as an inpatient at a Participating Hospital are covered if preapproved.

The following types of inpatient Hospital admissions are covered:

- Medical Admission. Inpatient services are covered for the treatment of medical conditions that need hospitalization. While the Enrollee does not need to be acutely ill at the time of admission, the Enrollee must require active and definite treatment, on an inpatient basis, or require diagnostic procedures that require hospitalization.
- Surgical Admission. Inpatient services are covered for treatment of acute or chronic surgical conditions, including certain elective procedures, when the procedure or surgical service requires the hospitalization of the Enrollee as an inpatient. All necessary prior in-Hospital care to prepare the Enrollee for surgery will be covered, except for defined exclusions (e.g., private duty nurses).
- Maternity Admission. Maternity care includes inpatient services for any conditions due to pregnancy or complications thereof.
- Diagnostic Admission. The Plan covers Hospital services for those Enrollees with a definite illness or disability that cannot be diagnosed while the Enrollee is cared for in the Enrollee's home, Provider's office, or Hospital outpatient department. Such diagnostic admissions are covered if the hospitalization is Medically Necessary. Hospital services are not covered if they are for the convenience of the Enrollee or the Provider, or for the saving of time or expense to the Enrollee in the performance of studies and tests.

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

- Semiprivate room, 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);

- Laboratory and pathology services;
- Chemotherapy for the treatment of certain malignant diseases, except when treatment is Experimental and/or Investigational (but such chemotherapy may require Prior Authorization by the Carrier, depending on the disease, to be covered);
- Inpatient physical therapy, when the service is essential to the treatment of the condition(s) for which the Enrollee was admitted to the Hospital, and subject to review by the Carrier;
- Oxygen and other gas therapy; and
- Maternity care and routine nursery care of the newborn during the Hospital stay of the mother for maternity care, when the mother is enrolled in the Plan.

2. Out-of-Network Hospitals

You may receive services at a Hospital not in the Plan's network. The Plan covers many of the same services at Out-of-Network Hospitals that it does at In-Network Hospitals. For the services that are covered, the difference is that You will be responsible for higher cost-sharing at an Out-of-Network Hospital. Please contact the Carrier for coverage information.

3. Non-Participating Hospitals

Because Non-Participating Hospitals do not have a contract with the Carrier, You will sometimes receive a bill and You will have to submit a claim to the Carrier for any services You receive from these Hospitals (except that sometimes, for Medical Emergencies, the Non-Participating Hospital will submit a claim directly to the Carrier). In a Medical Emergency or for Urgent Care services, the Plan will cover Your services received at a Non-Participating Hospital, except for any applicable cost share You may owe. Other than those narrow circumstances, the Plan will not cover services received from a Non-Participating Hospital and You could be responsible for the whole cost, unless You have other coverage outside the Plan that covers these services (e.g., Medicare, a Spouse's insurance). This means non-Medical Emergency treatment You get from a Non-Participating Hospital may result in a significant financial obligation for You. You should determine which Hospitals participate with Your Carrier before Hospital care is needed by calling Your Carrier. See the definition of "Participating Provider or Hospital or Facility or SNF" for more information.

If You are inpatient at a Non-Participating Hospital, the Plan can require You to transfer to a Participating Hospital when You are in a stable medical condition. The Plan will stop paying for Your inpatient Hospital stay if You refuse to transfer from a Non-Participating Hospital to a Participating Hospital.

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 outpatient service is covered and any other questions You may have on the use of supplies used during an outpatient service at a Hospital.

5. Prior Authorization

The Plan may require You, Your Provider, or Hospital to obtain Prior Authorization of all non-Medical Emergency services, non-maternity hospitalizations, and certain other services. This is sometimes called preapproval. Emergency admissions must be reported to the Carrier within 24 hours after the admission. You should inform Your Provider or Hospital that Prior Authorization 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 Prior Authorization.

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

Remember, the Prior Authorization 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 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 Prior Authorization from the Carrier for prescribing a length-of-stay 48 hours (or 96 hours as applicable) or less.

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. Coverage for such services is generally limited to 48 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

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

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 serious or permanent health-threatening or disabling condition, including certain Accidental Injuries, that requires immediate medical attention and treatment. The condition must be such that an individual who possesses an average knowledge of health and medicine could reasonably expect that if treatment is not immediately received, significant damage to bodily function could occur, permanent damage to the individual's health could occur, or the individual's life may be at risk. A Medical Emergency will be covered if the Enrollee's signs and symptoms, as verified by the Provider at the time of treatment and not on the basis of the final diagnosis, confirm a threat to life or bodily function.

If You are admitted to the Hospital as an inpatient or approved for admittance to an Observation unit for 24 or more hours, Your emergency room Copayment will be waived. If You are discharged without being admitted to the Hospital as an inpatient or You are not in Observation unit for more than 24 hours, You will be responsible for Your emergency room Copayment.

There may be two different charges for Medical Emergency care: Professional Charges – such as for services provided by the treating Provider; and Facility Charges – such as for the use of a Hospital emergency room.

- **Professional Charges** – The Plan covers Provider 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 Provider is not covered under the Medical 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.

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. Hospital Coverage Exclusions

The following exclusions apply to Hospital services (including both facility and professional changes) and coverage:

- Custodial, Domiciliary, convalescent, nursing home, or rest care;
- Hospital admissions and treatment for weight reduction or diet control (except for qualifying gastric bypass surgery);
- Surgery for cosmetic purposes, except for the correction of congenital abnormalities, traumatic scars and conditions resulting from Accidental Injuries, as well as to correct deformities from previous cancer or Medically Necessary surgery;
- When the care received by the Enrollee in the Hospital consists principally of diagnostic evaluation, physical therapy, tests or studies, environmental control, X-ray examination, laboratory examination, electrocardiograph, basal metabolism test, or reduction of weight by diet control;
- When a diagnosis has already been established and the Enrollee is admitted to verify the diagnosis. In such cases, evidence on the Hospital bill and/or doctor service report must clearly establish that specific therapy requiring hospitalization was administered in order to be covered. However, diagnostic admissions may be covered in the case of an infant, child, or elderly person in a weak or infirm condition as determined by the Carrier. The Carrier may consider the following factors:
    - Apparent condition and general state of health upon admission (e.g., acutely ill, in severe pain, extreme debilitation);

  - Onset and duration of illness and severity of symptoms (e.g., sudden, acute onset as opposed to vague complaints);
  - Findings upon physical examination (e.g., pain, bleeding, increased temperature); or
  - Specific or definitive treatment rendered which could not be administered on an outpatient basis;

- Admissions for oral surgery where a concurrent hazardous medical condition, such as a serious blood dyscrasia, unstable diabetes, or a severe cardiovascular condition, do not exist;
- Services and supplies for routine dental care;
- Inpatient dental treatment or extraction of teeth. Apprehension on the part of the Enrollee, regardless of age, does not entitle the Enrollee to benefits for inpatient dental treatment;
- Leaving a Hospital contrary to medical advice. Expenses incurred by an Enrollee as a result of leaving a Hospital or other health care facility against the medical advice of the attending Provider within 72 hours after admission;
- Professional services of Hospital staff or employees, including but not limited to services of doctors in training, nursing services, and physician assistants;
- Expenses for all medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery when the services, procedures, prescription of drugs or prophylactic surgery is prescribed or performed for the purpose of: (i) avoiding the possibility of risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results, except for limited exceptions associated with certain metastatic or relapsing cancer (please contact the Carrier for coverage information); or (ii) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder (except in the case of prophylactically Medically Necessary procedures, or when the services or procedures are based on the results of amniocentesis, chorionic villus sampling (CVS), or alphafetoprotein (AFP) analysis, which are covered);

9. 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.

10. Facility Fees

The Plan will cover the facility fee amounts charged by most outpatient facilities and doctors' offices. If You would like to be sure if a facility's fees will be covered, You should contact the Carrier before getting services at the facility.

11. 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 Provider'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 Provider services and applicable facility charges at an urgent care center will be paid by the Plan. A copayment will apply to such services.

12 Retail Health Clinics

Retail Clinics can provide You with health care for non-life-threatening or non-Medical 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 Clinic. A copayment will apply to such services. Non-Medical Emergency and non-urgent care services received at Out-of-Network Retail 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 referral by a Participating Provider. Home health care is only covered when provided by a Participating Provider. 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 provided 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 for physical therapy, occupational therapy, or speech evaluation, and each home health aide visit is considered the equivalent of one home health care visit.

1. Home Health Care Agency Covered Benefits

The following home health care services are covered when provided and billed by a Home Health Care Agency approved by the Carrier:

- General nursing services;
- Physical therapy, occupational therapy, and speech therapy (may be provided and billed Hospital outpatient department or Freestanding Outpatient Physical Therapy Facility);
- Social service guidance and dietary guidance;
- Part-time health aide service by a home health aide employed by an approved Home Health Care Agency if the Enrollee is receiving certain other covered home health services and the Enrollee cannot be treated without the home health aide service;
- Laboratory tests;
- Drugs, biologicals, and solutions; and
- Medical supplies which are essential to administer the at-home medical regimen ordered by the Provider. Covered medical supplies include items such as bandages, dressings, splints, hypodermic needles, catheters, colostomy appliances, and oxygen.

Intravenous (IV) infusion therapy services in the home are covered under home health care coverage. This includes all coverage of services directly related to infusion therapy, including DME, parenteral and enteral methods of hyperalimentation, chemotherapy, and supplies. Related nursing services and applicable prescription drugs are also covered. The following rules apply to coverage of such home IV infusion therapy services:

- The Homebound requirement will be waived with respect to home infusion therapy Enrollees; and
- The services must be delivered by a home infusion therapy accredited provider.

2. Home Health Care Agency Limitations and Exclusions

- Expenses for any Home Health Care Agency services other than part-time, intermittent skilled nursing services and supplies, except when the services of home health aides are covered under this Plan;
- Expenses under a Home Health Care Agency program for services that are provided by someone who ordinarily lives in the Enrollee's home or is a parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the Enrollee or when the Enrollee is not under the continuing care of a doctor;
- Expenses for a homemaker, Custodial Care, childcare, adult care or personal care attendant, except when provided by home health aides that are covered under home health care services;

- Expenses for transportation to or from a place outside the Enrollee's home to receive a home health care service;
- Supplies such as elastic stockings and personal comfort items or equipment;
- Appliances such as Hospital beds, oxygen tents, walkers, wheelchairs, or orthotics;
- Physician services;
- Private duty nursing services; and Housekeeping services.

E. HOME HEMODIALYSIS AND HEMOPHILIA COVERAGE

1. Home Hemodialysis Coverage

Hemodialysis (use of a kidney machine) or peritoneal dialysis is a covered service in the Enrollee's home when the treatment is of a chronic, irreversible kidney disease. Prior hospitalization is not required for home hemodialysis to be covered. Treatment must be arranged through the Enrollee's attending Provider during the establishment of the treatment program and a Participating Hospital hemodialysis program that has been approved by the Carrier.

Prior to installation of the dialysis machine, the Enrollee's place of residence must have access to electrical power and water supply appropriate for the hemodialysis equipment. The owner of the Enrollee's place of residence must give written permission before home hemodialysis equipment is installed.

2. Home Hemodialysis Covered Benefits

The Plan covers the following home hemodialysis expenses for Enrollees:

- The purchase, rental, or lease of a hemodialysis machine from a Participating Hospital and/or agency and placed in an Enrollee's home, when the Enrollee's home is deemed to be the most convenient and desirable setting for hemodialysis treatment by the Enrollee's attending Provider and a Participating Hospital hemodialysis program;
- Essential installation costs of home hemodialysis equipment and the subsequent maintenance or repair of such equipment;
- Benefits are payable for attaching the home dialyzer to existing power, water and disposal systems but are not payable for the cost of obtaining such systems;
- A water softening system is covered when used to pre-treat water to be purified by a reverse osmosis (RO) unit for home dialysis if:
    - The manufacturer of the RO unit has set standards for the quality of water entering the RO (i.e., the water to be purified by the RO must be of a certain quality if the unit is to perform as intended);

  - The water of the home where home dialysis will be performed is demonstrated to be of lesser quality than required; and
  - The softener is used only to soften water entering the RO unit, and thus used only for dialysis. The softener does need to be built into the RO unit but must be an integral part of the dialysis system.

- The Participating Provider's expenses incurred or resulting from training the Enrollee, family members or any other individual who needs to assist the Enrollee with the operation of the dialyzer in the home;
- Related laboratory tests;
- Consumable and expendable supplies, such as the dialysis membrane, the dialysis solution, tubing, and drugs required during dialysis, when purchased through and billed by a Participating Hospital;
- The full cost of treatment drugs required during dialysis, supplies, solutions, or other consumable and/or expendable items purchased for home hemodialysis;
- The cost of removing the hemodialysis equipment from the Enrollee's home when the Enrollee's need for the equipment ends.

3. Home Hemodialysis Exclusions

The following exclusions apply to home hemodialysis coverage:

- Provider services related to dialysis treatments in the home;
- Services and products not supplied by a Participating Hospital;
- Services provided by family members or other individuals trained and assisting in the dialysis procedure;
- Training of individuals by other than Participating Providers;
- Charges for electricity or water used in the operation or maintenance of the dialysis machine;
- After the initial installation, any subsequent costs incurred in moving the dialyzer to another location within the Enrollee's place of residence are not covered;
- Expenses incurred in the installation of a dialysis machine which are not essential to its operation;
- Services provided by an agency or organization providing "back up" assistance in home hemodialysis, including the services of Hospital personnel sent to the Enrollee's home, or for other persons under contract with the Participating Hospital.

4. Home Hemophilia Coverage

The Plan covers certain home hemophilia benefits to Enrollees with hemophilia. Enrollee selection and training for home hemophilia treatment must be handled by a treatment center that conforms to the qualifying policies and guidelines established by the state Hemophilia Society and approved by the Carrier.

The Plan covers the medication and supplies necessary for the treatment of hemophilia in the Enrollee's home, when prescribed by a Participating Provider qualified to treat Enrollees with hemophilia according to the guidelines established by the Hemophilia Society of each state. The Plan also covers in-home training as a home hemophilia benefit.

The following medications and supplies are covered under the hemophilia benefit:

- Antihemophilic factor (AHF);
- Benadryl or other appropriate antihistaminic agents; and
- Syringes, needles and other supplies required to inject the AHF.

Experimental and/or Investigational drugs and treatment are not covered.

F. HOSPICE COVERAGE

Hospice is care designed to give supportive care to people in the final phase of a terminal illness and their families and focuses on comfort and quality of life, rather than cure. Hospice care for terminally ill Enrollees, 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 treat any other illnesses or conditions that would normally be covered under the Plan. Although Hospice care does not aim to cure the terminal illness, it may treat potentially curable conditions such as pneumonia and bladder infections that arise while someone is terminally ill.

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

The terminally ill Enrollee (generally those with less than six months to live) must have written certification from a Provider that he or she is terminally ill and meets the criteria for life expectancy. The Enrollee must file an election statement with the Hospice program agreeing to the terms of Hospice care.

The Plan covers the following services for Enrollees admitted to an approved Hospice program:

Nursing care provided by or under the supervision of a registered nurse;

- Medical social services provided by a social worker under the direction of a Provider;
- Provider services;
- Counseling services provided to the Enrollee, family members and/or other persons caring for the Enrollee at home;
- General inpatient care provided in a Hospice inpatient unit;
- Medical appliances and supplies;
- Physical, occupational and speech therapies;
- Continuous home care provided during periods of crisis as necessary to maintain the Enrollee at home;
- Respite care;
- Bereavement counseling;
- Care rendered in a nursing home with Hospice support;
- Home health aide services; and
- Expenses for a homemaker, Custodial Care, childcare, adult care or personal care attendant.

G. SURGICAL AND MEDICAL COVERAGE

1. Covered Surgical and Medical Benefits

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 Prior Authorization;
- Payment for digital mammograms and 3D mammograms is limited to the Allowed Amount for standard mammograms;

- Immunizations and vaccinations recommended by the Center for Disease Control's Advisory Committee on Immunization Practices;
- Behavioral-based smoking cessation program;
- Mastectomy;
- Chemotherapy may be covered under either the medical or prescription drug benefit;
- Sterilization (but sterilization reversals are not covered);
- Plastic and reconstructive surgery if to correct congenital anomalies and conditions resulting from Accidental Injuries or traumatic scars, to correct deformities resulting from cancer surgery, or following Medically Necessary surgeries or procedures;
- Laser surgery if the alternative procedure is covered;
- The following anesthesia services are covered:

    a. For the administration of anesthetics, when provided by the Provider who is operating, and when required by, and performed in conjunction with, another covered service;

    b. Anesthesia services provided by a Provider for covered services in all settings that are appropriate for the covered surgical or diagnostic service being performed, including inpatient Hospital, outpatient Hospital, free-standing Ambulatory Surgical Facility/Center, and Provider's office; and

    c. Administration of anesthesia by a Certified Registered Nurse Anesthetist (CRNA) or an Anesthesia Assistant (AA) working under the medical direction of an anesthesiologist who is available for immediate attendance. CRNA services are also covered if performed under the general supervision of a Physician who is not an anesthesiologist and who is available for immediate attendance. Anesthesia services performed by CRNAs or AAs are covered if performed in the office, inpatient Hospital, outpatient Hospital, or freestanding Ambulatory Surgical Facility/Center settings.

- Technical surgical assistance: Services by a Provider or a physician assistant who actively assists the operating Provider, when Medically Necessary and when related to covered surgical or maternity services and under the scope of licensed practice;
- Maternity care: Services of a Provider or a certified nurse-midwife, including usual prenatal and postnatal care, are covered when received in a Hospital or In-Network Facility. For each pregnancy, coverage is also provided for routine prenatal laboratory examinations that are performed in connection with normal maternity care. Covered obstetrical services provided by a certified nurse-midwife are limited to basic ante partum care, normal vaginal deliveries, and postpartum care. Certified

nurse-midwives are reimbursed only for deliveries occurring in the In-Network Facility inpatient setting or in a birthing center that is Hospital affiliated, state licensed and accredited and approved by the Carrier;

- Initial Hospital inpatient examination of a newborn child by a Provider other than the delivering Provider, certified nurse-midwife or the Provider administering anesthesia during delivery;
- Therapeutic and elective abortion services are covered when Medically Necessary. The service must be legal in the state where rendered and provided by a licensed provider;
- Medically induced abortion by oral ingestion of approved medication (e.g., Mifeprex or Mifepristone) is eligible for coverage under the Medical or Prescription Drug benefit. Medically induced abortions, family planning services, and contraceptive counseling are also eligible for coverage when provided as a telehealth encounter. The service must be legal in the state where rendered and provided by a licensed provider;
- Extra corporeal shock wave lithotripsy (ESWL), if performed by a Provider approved by the Carrier and meeting Plan standards including the treatment of selected conditions/diagnosis;
- Radiation therapy and chemotherapy for certain types of malignant conditions (e.g., cancer) (may require Prior Authorization, depending on the particular therapy and condition);
- Therapeutic radiology: Coverage is provided for certain treatment of conditions by external or internal beam radiation, or via radioactive isotope treatments, and includes the cost of materials provided. Some therapeutic radiology services are only indicated for treatment of certain conditions and may require Prior Authorization from the Carrier. Enrollees can contact the Carrier to determine whether a given therapeutic radiology service requires Prior Authorization;
- Coverage for proton beam therapy, if preapproved by the Carrier;
- The following diagnostic laboratory, pathology and other services are covered, with the limitations set forth below:

    a. Medically Necessary laboratory and pathological examination for the diagnosis of any condition, disease, or injury;

    b. Coverage is provided for laboratory and pathological services per Enrollee per year to detect cancer of the female genital tract when prescribed by a Provider;

    c. Echocardiography is covered, if performed by a board certified or board eligible cardiologist; and

d. When a covered diagnostic test requires injection of a drug, biological or solution in order to perform the test, the drug, biological or solution, and the injection of it are covered, subject to Carrier billing and reimbursement practices.

- Well Child Care: Coverage is available as defined by the American Academy of Pediatrics (AAP) for visits to In-Network Providers for children under two years of age;
- Screenings: Coverage will be provided for those screenings that receive an A or B recommendation from the U.S. Preventive Services Task Force without cost sharing when prescribed by an In-Network Provider and administered by an In-Network Provider;
- Contraceptive Services: Medical and surgical coverage for contraceptive services is covered except for those devices and medications available over-the-counter;
- Expenses for medical or surgical treatment of obesity (bariatric surgery), including drug therapy if covered by the prescription drug benefit, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, skin reduction procedures/treatment (if the skin reduction procedures/treatment meets the coverage criteria in the medical policy of the Plan and administered by the Carrier), and any complications thereof. To determine if the Plan covers skin reduction procedures/treatment in Your situation, please call and ask the Carrier;
- Expenses for surgical and associated medical treatment of gender dysphoria, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, if the Enrollee meets the coverage criteria in the medical policy of the Plan and administered by the Carrier. The medical policy will include any prerequisites for coverage of the services, as well as any ongoing exclusions. To determine if the Plan covers expenses for surgical and associated medical treatment of gender dysphoria in Your situation, please call and ask the Carrier;
- Appropriate mental health treatment is also covered, subject to the restrictions of the Plan, for such an Enrollee;
- Expenses for certain medical injections are covered. Covered injections are subject to criteria established by the Plan, and as such, not all injections are a covered service. Injections may be covered under the medical benefit or the prescription drug benefit. Injections may not be covered under the medical benefit but may be covered as a prescription drug benefit (or vice versa) and subject to those injection Plan rules and criteria. Prior authorization may be required;
- Chiropractic care received from an In-Network Provider, including adjustment manipulation for subluxation of the spine, up to 24 visits per Plan year. Diagnostic radiological services and Medical Emergency first aid related to the spine and related bones and tissues are also covered);

- Allergy testing and treatment;
- Pulmonary rehabilitation and cardiac rehabilitation; and
- Diabetes education.

See Your Schedule of Benefits, Health Care Benefits Summary or Benefit Highlights Letter(s), and other materials from Your Carrier for details and limitations to the above-listed coverages.

2. Surgical and Medical Benefit Exclusions

The following exclusions apply to surgical and medical benefits:

- Facility charges for surgical services provided at Out-of-Network Ambulatory Surgical Center or Facility;
- Artificial insemination or in vitro fertilization;
- Refractive keratoplasty (radial keratotomy) or similar vision-related procedures;
- Treatment of jaw joint or jaw hinge problems, including temporomandibular joint syndrome and craniomandibular disorders;
- Physicals for pre-marital, pre-employment, or similar examinations or tests not directly related to diagnosis of illness or injury;
- Out-of-Network virtual visits. Expenses related to an online internet consultation with a doctor or other Provider, also called a virtual office visit/consultation, doctor-patient web service or doctor-patient e-mail service, including receipt of advice, treatment plan, prescription drugs, or medical supplies obtained from an online internet Out-of-Network Provider. Similar services with an In-Network Provider may be covered under the terms of the Plan;
- Expenses for an autopsy;
- Private room in a health care facility unless the use of a private room is Medically Necessary. If, for any reason, the Enrollee stays in a room that is less expensive than the room covered by this Plan, the Enrollee is not entitled to payment of the difference in charges;
- Expenses for the services of a medical student, resident, or intern;
- Stand-by doctors or Providers. Expenses for any doctor or other Provider who did not directly provide or supervise medical services to the Enrollee, even if the doctor or Provider was available on a stand-by basis;
- Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, terrorist act, rebellion, or invasion, except as required by law;

- Expenses incurred for injury or sickness resulting from the release of nuclear energy;
- Expenses for acupuncture and/or acupressure (except that acupuncture is a covered benefit for TCN Enrollees);
- Expenses for chelation therapy, except as may be Medically Necessary for treatment of heavy metal poisoning;
- Expenses for prayer, religious healing, or spiritual healing;
- Expenses for naturopathic, naprapathic, and/or homeopathic services or treatment/supplies;
- Cosmetic services. Surgery or medical treatment to improve or preserve physical appearance, but not physical function, is not covered. Enrollees may be required to use a Prior Authorization process to determine if a proposed surgery or service will be considered cosmetic surgery or Medically Necessary reconstructive services. Cosmetic surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation/breast reduction, elimination of redundant skin of the abdomen (unless the skin reduction procedures/treatment meets the coverage criteria in the medical policy of the Plan and administered by the Carrier; to determine if the Plan covers elimination of redundant skin of the abdomen in Your situation, please call and ask the Carrier), surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to an Enrollee's appearance, treatment of varicose veins or other medical or surgical treatment intended to restore or improve physical appearance.x This does not include those services covered under the treatment for gender dysphoria under the policy of this Plan;
- Infertility services for non-Spouse Dependents;
- Certain contraceptives. Expenses for non-prescription contraceptives, such as condoms, are excluded;
- Certain fertility and infertility services. Expenses for surrogate parenting, cryostorage of eggs or sperm, adoption, infertility donor expenses, fetal implants, reversal of sterilization procedures, and fetal reduction services are excluded. Prenatal services, maternity services, and prescription drug services related to a pregnancy incurred by an Enrollee acting as a surrogate mother (gestational carrier) are not covered. For the purpose of this Plan, the child of a surrogate mother will not be considered a Dependent of the surrogate mother or her spouse, if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth;
- Expenses for childbirth education, Lamaze classes, breast feeding classes;
- Expenses related to cryostorage of umbilical cord blood or other tissue or organs;
- Expenses for massage therapy, Rolfing, and related services;

- Certain foot/hand care services. Expenses for routine foot care (including, but not limited to, trimming of toenails, removal or reduction of corns and calluses, removal of thick/cracked skin on heels, foot massage, preventive care with assessment of pulses, skin condition and sensation), or hand care including manicure and skin conditioning are not covered. Routine foot care from a podiatrist may be covered for Enrollees with diabetes or a neurological or vascular insufficiency affecting the feet;
- Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis. However, the Plan covers wigs and related supplies for Enrollees who are suffering hair loss from the effects of chemotherapy, radiation, or other disease treatments;
- Expenses for speech therapy for functional purposes including, but not limited to, stuttering, stammering, and conditions believed to be of psychoneurotic origin or for childhood developmental speech delays and disorders;
- Expenses for treatment of delays in childhood speech development unless as a direct result of an injury, surgery, or the result of a covered treatment;
- Expenses for tobacco/smoking cessation products such as nicotine gum or patches;
- Expenses for over-the-counter tobacco/smoking cessation products, even if prescribed by a doctor;
- Expenses for medical or surgical treatment of severe underweight. This includes, but is not limited to, high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia, or acute starvation. Severe underweight means a weight more than 25% under normal body weight for the Enrollee's age, sex, height, and body frame based on weight tables generally used by doctors to determine normal body weight; and
- Routine vision care services (except that the Vision plan covers certain routine vision services) and supplies

3. 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 services from an In-Network Provider and arrange Your second and/or third opinion with the Carrier.

If You receive a second opinion, services performed as part of that second opinion are covered, including the Provider's consultation and any necessary X-ray, laboratory services, and other tests. If the Provider who provides the second opinion disagrees with the recommendations of the first Provider, the Plan will cover a third opinion from an In-Network Provider if You wish to obtain one.

H. 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 a Non-Participating Provider, the Carrier may pay the Plan's Allowed Amount for covered services directly to You and You will be responsible to pay the Non-Participating Provider's bill. Also, if the ambulance company is a Non-Participating, in addition to being responsible for any cost-sharing You owe, the ambulance company may also bill You for the balance between the Plan's Allowed Amount and the total amount of its bill. You have coverage for a range of ambulance services, including, but not limited to:

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 Enrollee who must be taken to a non-Hospital facility for a covered diagnostic examination (if the non-Hospital facility is a Participating Facility), when the services are not available in the Hospital to which the Enrollee 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 putting the Enrollee's life at risk;
- 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 Enrollee;
- Charges for basic life support services. A standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as basic life support services. Basic life support consists of services that provide for the initial stabilization and transport of an Enrollee;
- Charges for advanced life support services. A standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as advanced life support services. Advanced life support is acute Medical Emergency treatment procedures with Provider involvement;
- Mileage charges. A charge per mile for distances traveled while the Enrollee occupies the ambulance;
- Waiting time. A charge for waiting time involved in round trip transport of an Enrollee from a Hospital to another treatment site and return to the same Hospital; and
- Non-transport when patient pronounced deceased after ambulance arrival.

2. Air and Boat Ambulance

If air or boat ambulance is required, the Plan covers charges for fixed or rotary wing ambulance or boat ambulance services, subject to Coinsurance and restrictions including mileage limitations. The Plan covers a standard charge per trip, inclusive of use of the air transport or boat transport, supplies, and personnel required to perform needed services. Non-Medical Emergency air ambulance transport must be preapproved by the Carrier before such transport will be covered. That Prior Authorization 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-Medical Emergency transport. If You use a Non-Participating air or boat ambulance provider, the Plan will try to reach an agreement with the air or boat ambulance 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 Non-Participating Provider's billed charges. If it is determined that transport by ground ambulance would have been appropriate, payment for air or boat ambulance services will be limited to the amount that would have been paid for a ground ambulance.

3. Ambulance Limitations and Exclusions

The following limitations and exclusions apply to ambulance coverage:

- Coverage is limited to the Allowed Amount for transporting an Enrollee within a metropolitan area or to the nearest facility qualified to treat the Enrollee, as appropriate under the terms of the Plan;
- Coverage does not include the following:
  - Transportation in a vehicle not qualified as an ambulance;
  - Transportation for Enrollee, family, or Provider convenience;
  - Service rendered by fire departments, rescue squads or others whose fee is in the form of a voluntary donation;
  - Transfers not Medically Necessary;
  - Fees billed by Providers for professional services rendered to Enrollees transported by ambulance; and
  - Services payable through an existing arrangement for transfer of Enrollees, where no additional charge is usually made, whether or not such services were immediately available;

- The following services are not covered as separate charges; such charges are included in the benefit payment for the standard charge per trip for basic or advanced life support services and are not separately payable:

    - Use of specific equipment or devices;
    - Gases, fluids, medications, dressings, or other supplies;
    - First aid, splinting, or any Medical Emergency services or personal service procedures; and
    - Vehicle operators, attendants, or other personnel.

I. OUTPATIENT PHYSICAL THERAPY, OUTPATIENT OCCUPATIONAL THERAPY, AND/OR SPEECH THERAPY

You have coverage for outpatient physical therapy, outpatient occupational therapy, and speech therapy if ordered by Your Provider. Before receiving outpatient physical, occupational, or speech therapy, please call and ask the Carrier to determine if the services will be covered for Your condition, and if the outpatient Provider is an In-Network Provider. 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, 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.

Coverage Limitations and Exclusions

The following limitations and exclusions apply to outpatient physical therapy, outpatient occupational therapy, and speech therapy coverage:

- Multiple therapy treatments occurring on the same day (whether physical, 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 Enrollee's illness. It is not covered for long-standing chronic conditions or inherited speech abnormalities (except that it is covered for Dependent Children under six years of age who have congenital and severe developmental speech disorders, when not available through public agencies, the state, or school; if a Dependent Child turns age six while such therapy is in process, coverage will continue until the 60 visit maximum for that calendar year is exhausted);

- Coverage for physical therapy is limited to when You have an expectation of improvement in a reasonable and predictable period of time and improvement is documented on a periodic basis in Your medical record;
- Physical therapy and occupational therapy are not covered for the treatment of congenital conditions or when provided solely to maintain musculoskeletal function;
- Speech therapy is not covered for educational learning disabilities (e.g., dyslexia), deviant swallow or tongue thrust, or mild developmental speech or language disorders; and
- Inpatient admissions that are principally for physical, occupational, or speech therapy are not covered.

J. MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE

You have coverage for mental health and substance use disorder services under the Plan. The Plan may require that You receive Prior Authorization before receiving mental health or substance use disorder services.

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

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

- Outpatient therapy visits for mental health outpatient care at an In-Network Facility and performed by a Participating Provider;
- Outpatient therapy visits for substance use disorder outpatient care at an In-Network Facility and performed by a Participating Provider;
- Up to a maximum of 45 days annually (combined inpatient and residential) mental health inpatient care within a benefit period at a Hospital or Residential Treatment Facility for covered psychiatric illness(es) if the condition requires continuing professional care on an inpatient basis. These visits can be consecutive or intermittent. If an Enrollee is not inpatient at least 60 consecutive days, the 45-day benefit renews;
- Up to a maximum of 45 days annually (combined inpatient and residential) substance use disorder inpatient care within a benefit period at a Hospital or Residential Treatment Facility for treatment of an emotional disorder causing or resulting from an addiction if the condition requires continuing professional care on an inpatient basis. These visits can be consecutive or intermittent. If an Enrollee is not inpatient at least 60 consecutive days, the 45-day benefit renews;

- Up to a maximum of 35 visits annually in an approved outpatient mental health Partial Hospitalization Treatment Facility; and
- Up to a maximum of 35 visits annually in an approved outpatient substance use disorder Partial Hospitalization Treatment Facility.

Illness sometimes needs to be covered under both medical benefits and mental health benefits. If this happens, medical benefits cover the usual length of hospitalization for post-partum or post-surgical care; subsequent mental health care would then be charged against the mental health inpatient covered services.

1. Covered Substance Use Disorder Services

The following substance use disorder services are covered:

- Dispensing methadone;
- Testing urine specimens;
- Physical exams;
- Certain other diagnostic procedures;
- Professional services, if they are provided in relation to the substance use disorder services; and
- Detoxification, if at a Participating Hospital or Residential Treatment Facility (and this will be charged against the 45-day mental health and substance use disorder benefit period).

2. Covered Mental Health Services

Counseling services are covered for Enrollees only; family counseling services are only available for Enrollees under the Plan when delivered by the same Provider who is performing services for the individual family member under treatment.

3. Limits On Out-of-Network Mental Health and Substance Use Disorder Coverage

Out-of-network services for mental health and substance use disorder are limited under the Plan:

- Inpatient visits for mental health and substance use disorder services must be to an In-Network Facility except in a Medical Emergency;
- The Plan covers outpatient mental health and substance use disorder services performed by In-Network Providers and Out-of-Network Providers, subject to certain Plan restrictions;

a. Payments for mental health or substance use disorder services provided by an Out-of-Network Provider will be limited to the amounts the Plan pays an In-Network Provider for the same service; and

b. Out-of-Network Provider services for substance use disorder are only covered after Prior Authorization from the Carrier.

- Visits to Non-Participating non-physician practitioners, including but not limited to, psychologists, nurse practitioners, social workers, and addiction counselors (when billed separately and not part of an inpatient stay) are not covered.

4. Mental Health Coverage Exclusions

In addition to the other Plan exclusions, mental health services are subject to the following exclusions:

- Mental health services for intellectual and learning disabilities, except that certain such services are covered when performed for evaluation or diagnosis;
- Treatment for mental conditions not classified as emotional or personality disorders;
- Services performed for the purpose of research and not generally accepted by the medical profession;
- Educational therapy, defined as academic tutoring for Dependent Children to relieve learning deficits and services intended solely to correct educational deficits, whether developmental or of organic origin. Educational deficits include congenital or developmental learning disturbances such as dyslexia, mathematics and reading defects, word blindness/deafness, and strephosymbolia. Educational deficits also include speech disturbances, such as stammering, stuttering, cluttering, and lisping;
- Staff training services and services primarily for the advancement of the academic and/or professional education or training of the Enrollee (regardless of the diagnosis or symptoms);
- Mental health services for mental disorders and illnesses that, according to generally accepted professional standards, are not amenable to favorable modifications. Except that the Plan covers certain services when necessary to determine that such disorders and illness are not amenable to favorable modification;
- Psychological and laboratory tests billed when used for routine screening of normal range individuals, who are largely symptom free. Only those tests ordered by a doctor and authorized by the Plan will be considered for reimbursement. The doctor should selectively order only those services that are determined to be necessary for each Enrollee;

- Indirect services, such as supervision conferences that take place between the psychiatrist and primary therapist;
- Pre-marital counseling;
- Marriage counseling;
- Relaxation therapy;
- Weight reduction/control;
- Didactics (except that didactics benefits from a structured Intensive Outpatient Program (IOP) are covered);
- Services that are not yet generally accepted by the medical profession or for which there is no proven scientific validity;
- Treatment or counseling of Enrollees with sexual dysfunction in the absence of an underlying emotional illness. In order for the Plan to cover such treatment or counseling, the Enrollee's medical record must contain a history and physical examination to rule out any physiological cause and clearly establish the causal factor(s) as psychogenic. The Enrollee's partner may participate in treatment, but the Plan will only pay for the Enrollee's treatment;
- L-Tryptophan, except that the Plan covers treatment of diagnosed and documented nutritional deficiency states;
- Vitamins, except that the Plan covers treatment of diagnosed and documented nutritional deficiency states;
- Consultation with a mental health professional for purposes of deciding marital or child support and custody cases;
- Environmental ecological treatments;
- Megavitamin or orthomolecular therapy;
- Transcendental meditation;
- Rolfing;
- Z Therapy;
- Erhard Seminar Training;
- Primal therapy;
- Bioenergetic therapy;
- Carbon dioxide therapy;
- Guided imagery;
- Biofeedback;

- Sedative action electro stimulation therapy;
- Aversion therapy;
- Confrontation therapy;
- Hypobaric or normobaric oxygen therapy;
- Narcotherapy with LSD;
- Hemodialysis for schizophrenia;
- Training analysis (tutorial, orthodox);
- Sensitivity training;
- Crystal healing treatment;
- Poetry/art/music therapy;
- Court ordered treatment;
- Missed appointments;
- Eye Movement Desensitization Therapy (EMD);
- Services provided at non-approved sites;
- Services provided in excess of the benefit parameters;
- Therapy that is not conducted in real-time or does not meet Plan criteria for the setting;
- Routine psychological testing of individuals who are largely symptom free;
- Gambling addiction;
- Wilderness or recreational therapy (e.g., an organized program of leisure-based activity programs); and
- Diversional therapy, which may include activities that improve or sustain an Enrollee's skills of self-care and daily living.

5. Substance Use Disorder Coverage Limitations and Exclusions

In addition to the other Plan exclusions, substance use disorder services are subject to the following exclusions:

- Services provided at non-approved sites;
- Services provided in excess of the benefit parameters;
- Treatment for conditions not classified as substance use disorder;
- Routine psychological testing of Enrollees who are largely symptom free;
- Therapy that is not conducted in real-time or does not meet Plan criteria for setting; and
- Missed appointments.

6. General Coverage Limitations and Exclusions

In addition to the other Plan exclusions, both mental health and substance use disorder services are subject to the following exclusions and limitations:

- Coverage for substance use disorder treatment including dispensing methadone, testing urine specimens, or performing X-ray examinations or other diagnostic procedures does not include additional payment for professional services, unless a separate and distinct professional service, such as therapy, counseling, or psychological testing, is provided; and
- Coverage does not include testing if used for vocational guidance, training, or counseling.

K. SKILLED NURSING FACILITY COVERAGE

1. Overview of SNF Coverage

This Section VI(K)(1) provides an overview of the SNF coverage for the ECP and Humana Commercial plans. An overview of the SNF coverage for the TCN plan and how it works with Medicare can be found above in Section IV(H) in this SPD.

A SNF is a facility outside of the Hospital that provides nursing care 24 hours a day under the supervision of a health care professional. The Plan covers Medically Necessary stays at in-network and Out-of-Network SNFs for rehabilitation and further therapy. When the Plan covers Your in-network or Out-of-Network SNF stay, the Plan will cover it, less Your applicable Deductible and Coinsurance up to Your Out-of-Pocket Maximum. The Plan coverage is different for in-network and Out-of-Network SNFs.

2. In-Network SNF Benefits

Starting on the first day of your SNF stay through your date of discharge, the Plan will cover Your stay, as described under Section VI(K) Skilled Nursing Facility Coverage. The Plan will continue to cover stays in a SNF if you are discharged and readmitted to the SNF at any time during the calendar year.

The 100-covered day limit and the 60-day break between SNF stays, which apply to Out-of-Network SNF stays and are described immediately below, do not apply to In-Network SNF stays.

3. Out-of-Network SNF Benefits

This benefit per covered SNF stay is limited to 100 covered days under the Plan.

After an initial Out-of-Network SNF stay, the Plan requires that You stop receiving SNF services for a period of 60 days before further SNF benefits are covered. If You require additional SNF days after those 60 days, the Plan will cover your SNF stay.

You will also have coverage for another 100 days of Medically Necessary SNF care under the Plan at the beginning of each Plan Year, even if you have not stopped receiving SNF services for a period of 60 days.

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

The following Sections VI(K)(2) through (4) provide information regarding SNF coverage for the ECP, TCN and Humana Commercial plans. This Section VI(K)(1) provides an overview of the SNF coverage for the ECP and Humana Commercial plans.

a. SNF Coverage Requirements

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

- If You are enrolled in the ECP or Humana Commercial plans, Your stay must be preapproved. If You are enrolled in the TCN plan, Your stay must be either: (a) a covered benefit under Medicare; or, (b) preapproved by the Carrier if Your covered benefit under Medicare for a stay ends because Your stay exceeds the number of days covered by Medicare;
- The services are Medically Necessary for the treatment of Your condition;

- The SNF must be a Participating SNF and have a contract with the Carrier (no coverage at Non-Participating SNFs, although Medically Necessary care at Out-of-Network SNFs is covered);
- Your doctor has ordered the services You need for SNF care, which requires the skills of a health care professional, 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 health care 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 Enrollee 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 Enrollee's place of residence.

b. SNF Covered Benefits

If You are admitted to a SNF, the following services are covered when prescribed by the attending doctor and usually provided by a SNF or by a Hospital affiliated with a SNF:

- Provider medical visits, at the rate of two per week, in an approved SNF for general conditions;
- Semi-private room service, including general nursing service, meals, and special diets;
- Use of special treatment rooms;
- Laboratory examinations;
- X-ray and EKG;
- Physical, occupational, and speech therapy treatments;
- Oxygen and other gas therapy;
- Drugs, biologicals, and solutions used while the Enrollee is admitted at the SNF;
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings and casts; and
- Durable Medical Equipment, if payable under the provisions of this Plan.

c. SNF Coverage Limitations and Exclusions

In addition to those limitations set forth elsewhere in this SPD, the following SNF benefits that are not covered include stays for:

- Conditions that are not Medically Necessary or do not require skilled nursing services;
- Admissions that are principally for Domiciliary Care, for basic living assistance, or for treatment of tuberculosis;
- Adult foster care, assisted living, or Custodial Care (such as helping Enrollees get in and out of bed, bathe, dress, eat, use the toilet, walk, or take drugs or medications that can be self-administered);
- Enrollees who have reached their maximum level of recovery possible for their particular condition and no longer require treatment other than routine supportive care;
- Primary mental health illness, including drug addiction, chronic brain syndromes and alcoholism, without other specific medical conditions of a severity to require care under the Plan (except that the Plan covers short-term convalescent care for Enrollees with primary mental health illness and for whom prognosis for recovery or improvement is deemed favorable);
- Inpatient rehabilitation therapy services provided to an Enrollee who is unconscious, comatose, or is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to, cognitive rehabilitation, coma stimulation programs and services;
- Expenses for maintenance rehabilitation;
- Enrollees suffering senile deterioration who do not have a treatable medical condition requiring attention; or
- Services provided by Non-Participating SNFs.

L. PREVENTIVE SERVICES

This Section VI(L) provides an overview of the preventive services coverage for the ECP and Humana Commercial plans. An overview of the preventive services coverage for the TCN plan and how it works with Medicare can be found above in Section IV(F) in this SPD.

Take advantage of covered preventive services. You may prevent future health problems by using these 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, which can be located at the U.S. Preventive Services Task Force website.

Preventive services are excluded from the Annual Deductible, Copayment, and Coinsurance requirements when received from In-Network Providers.

Preventive services may have gender, age, or frequency limitations, such as Prostate-Specific Antigen tests being available only to individuals assigned male at birth 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.

M. PHYSICIAN OFFICE VISITS

This Section VI(M) provides an overview of the doctor office visit coverage for the ECP and Humana Commercial plans. An overview of the doctor office visit coverage for the TCN plan and how it works with Medicare can be found above in Section IV(G) in this SPD. The Plan does not cover doctor office visits for Medicare Enrollees and Dependents enrolled in the TCN plan.

The Plan covers doctor office visits for non-Medicare Enrollees and Dependents enrolled in the ECP or the Humana Commercial 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 covered office visits to that PCP will include at least one annual wellness visit, as well as unlimited additional Medically Necessary 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 office visits to specialist Providers too. These Medically Necessary office visits are also unlimited. However, Your cost-sharing will be higher per visit to specialist Providers than with visits to Your PCP. These visits can also be with a nurse practitioner or physician's assistant working with Your specialist Provider. This benefit also includes Your ability to get a second opinion. You should contact the Carrier to help You arrange such an office visit.

N. CASE MANAGEMENT

This Section VI(N) provides an overview of the case management coverage for the ECP and Humana Commercial plans. An overview of the case management coverage for the TCN plan and how it works with Medicare can be found above in Section IV(K) in this SPD.

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 an Enrollee 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.

O. 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.

P. HUMAN ORGAN TRANSPLANTS

This Section VI(P) provides an overview of the human organ transplant coverage for the ECP and Humana Commercial plans. An overview of the human organ transplant coverage for the TCN plan and how it works with Medicare can be found above in Section IV(L) in this SPD.

Human Organ Transplants are covered, subject to certain requirements including that they are Medically Necessary. Generally, 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 approved transplant centers and further details on which costs are covered.

1. Human Organ Transplant Coordination of Benefits

- Benefits paid by the Plan will be reduced by any amount payable from other sources, such as foundations, grants, governmental agencies or programs, research or educational grants, and charitable organizations. Any portion of the costs of the organ transplant and associated services covered by governmental, foundation, or charitable grant will reduce the coverage by the Plan proportionally;
- Any type of human organ or tissue transplant from a donor to a transplant recipient requiring surgical removal of the donated organ and tissue, are covered services under the Plan, according to the criteria outlined below and elsewhere in this SPD:

- When an Enrollee is the human organ recipient:
  - The Enrollee's costs are covered by the Plan;
  - The donor's costs are covered by the Plan if no other insurance or payor is available that covers the costs; and
  - Any cost-sharing associated with the donor will be the responsibility of the Enrollee.
- When an Enrollee is the human organ donor:
  - The Enrollee's costs are covered by the Plan; and
  - The recipient's costs are not covered by the Plan.
- When an Enrollee is the human organ donor, and an Enrollee is the recipient:
  - The Enrollee donor's costs are covered by the Plan;
  - The Enrollee recipient's costs are covered by the Plan;
  - Cost-sharing associated with the transplant is the ultimate responsibility of the recipient Enrollee.
- When a cadaver is the human organ donor, and an Enrollee is the recipient:
  - The Enrollee's costs are covered, except for any amounts covered by an organ procurement agency;
  - Any cost-sharing will be the responsibility of the Enrollee.

2. Human Organ Transplant Coverage

The Plan will cover, among others, the following human organ transplant services and expenses:

- Evaluation and procurement costs. Expenses incurred in the evaluation and procurement of organs and tissues are covered when billed by a Hospital. Charges for participation with registries for organ procurement, operating rooms, supplies, use of Hospital equipment and transportation of the tissue or organ to be evaluated are also covered. All such covered expenses will be charged against the Enrollee recipient's coverage if benefits to the donor or potential donor are not provided under some other health care coverage; and
- Immunizations for post-transplant Enrollees are covered up to 30 months after the human organ transplant.

3. Human Organ Transplant Coverage Limitations and Exclusions

In addition to those limitations set forth elsewhere in this SPD, the following human organ transplant benefits that are not covered include:

- Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including but not limited to, donor screening, acquisition/selection, organ or tissue removal, transportation, transplantation, postoperative services, drugs/medicines, and all associated complications;
- Expenses related to non-human (xenografted) organ and/or tissue transplants or implants (except that non-human heart valve implants are covered);
- Expenses for the cost of an organ or tissue sold rather than donated. Costs associated with the transplant, including the costs of the procedure, are also excluded when the Enrollee knows that the organ was purchased or when the Enrollee intends to sell his or her organ;
- Expenses for transportation and lodging costs;
- Expenses for transplant surgery and related services performed in a nondesignated facility;
- Expenses for routine storage cost of donor organs for the future purpose of transplantation;
- Expenses for certain services prior to your organ transplant surgery;
- Expenses for insertion and maintenance of an artificial heart or other organ or related device, including associated complications, except that the following are covered:
    - Heart valves;
    - Kidney dialysis; and
    - A ventricular assist device (VAD) (i.e., a mechanical pump used to assist a damaged or weakened heart in pumping blood):
        - Only when used as a bridge to a heart transplant; or
        - For support of blood circulation after open-heart surgery; or
        - For destination therapy (permanent mechanical cardiac support but only if there is approval from the FDA for that purpose, and the device is used according to the FDA-approved labeling instructions).

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

This Section VI(Q) provides an overview of the DME and P&O coverage for the ECP and Humana Commercial plans. An overview of the DME and P&O coverage for the TCN plan and how it works with Medicare can be found above in Section IV(M) in this SPD.

You have coverage for Medically Necessary durable medical equipment (DME) and prosthetic and orthotic (P&O) appliances prescribed by Your doctor. Generally, the DME and P&O appliance must be on the Plan-approved list of devices and must be supplied by a contracted Provider. You or Your doctor may contact Your Carrier for Prior Authorization, claims processing, locating Network Providers, and for any other questions or concerns. When a rental period extends beyond the expiration of the original prescription, the doctor must recertify by another prescription that the equipment continues to be reasonable and Medically Necessary for the treatment of the illness or injury or to improve the functioning of a disabled body part. If the recertification is not submitted, coverage of the equipment ends on the date indicated on the original prescription for duration of need or 30 days after the date of death the Enrollee, whichever is earlier.

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 You use an Out-of-Network DME Provider or supplier, it is not covered, and the Plan will pay no benefits. DME and P&O appliances must be Medically Necessary and covered by the Plan.

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.

2. DME Coverage

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

- Equipment that meets Plan standards, is appropriate for use in the home, and is generally 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);
- Equipment that is used in a Hospital or SNF, or when used outside of the Hospital or SNF, and rented or purchased from the Hospital or SNF at discharge;
- Special features necessary to adapt otherwise covered equipment;

- Equipment that appears on a covered list of equipment maintained by the Carrier and approved by the Plan;
- Neuromuscular stimulators;
- External electromagnetic bone growth stimulators, in certain approved cases;
- Pronged and standard canes (when purchased);
- Continuous Passive Motion Devices (shoulder and elbow): These items will be covered when prescribed by a doctor following shoulder or elbow surgery for a period of no more than 21 days total. The total 21 days applies to days that equipment is used in the Hospital and home;
- Alcohol wipes, but only if they are used in conjunction with qualified diabetic testing supplies. Alcohol wipes will not be covered for any other use;
- Phototherapy (Bilirubin Light): This item is covered for Dependent Children under the age of one having a diagnosis of hyperbilirubinemia;
- Cranial Helmets: A cranial helmet will be covered for Enrollees with a diagnosis of positional plagiocephaly or congenital torticollis; and
- Special features which are necessary to adapt otherwise covered equipment for use by Dependent Children.

3. P&O Appliance Coverage

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

- 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 disease treatments);
- 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 and/or Investigational appliances or devices), used externally while in the Hospital as part of regular Hospital equipment, or prescribed by a doctor for use outside the Hospital.

4. DME and P&O Appliance Coverage Limitations and Exclusions

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 and/or Investigational;
- Pulse oximeters;
- Supplies for wound care;
- Rental charges that exceed the purchase price of the equipment;
- Purchases ordered before the Enrollee's coverage under the Plan starts;
- Rental charges before the Enrollee's coverage under the Plan starts;
- Rental charges after the Enrollee's coverage under the Plan terminates;
- Hearing aids, eyeglasses, and such non-rigid appliances and supplies as elastic stockings, garter belts, arch supports, corsets, and corrective shoes unless the shoe is attached to a Medically Necessary brace;
- Experimental and/or Investigational devices;
- Expenses for any items that are not corrective appliances, P&O appliances or DME including, but not limited to, air purifiers, swimming pools, spas, saunas, escalators, motorized modes of transportation, pillows, mattresses, water beds and air conditioners;
- Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, P&O appliances or DME; and
- Expenses for non-durable supplies.

R. 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 Medical 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;

- When You are on a ship in the territorial waters adjoining the U.S.; or
- The Enrollee is a citizen of Canada and permanently resides there. The Plan will offer Canadian Enrollees a single plan option, different from the plan options and with different benefits than those plans described in this SPD.

S. COVERAGE EXCLUSIONS

In addition to those limitations set forth elsewhere in this SPD, the following medical services, supplies, and other health care expenses that are not covered include:

- Services provided prior to the effective date of coverage or after the termination of coverage under the Plan;
- Services that are not Medically Necessary;
- Care, services, therapy, treatment, supplies, and devices, and drugs that are Experimental and/or Investigational in nature;
- Services not ordered by a Provider;
- Services covered in any way by federal or state programs, except as the SPD describes above with the Plan as secondary payor or when federal law requires the Plan to cover You as primary;
- Expenses incurred by any Enrollee for injuries resulting from or sustained as a result of the commission, or attempted commission by the Enrollee, of an illegal act that involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Enrollee. If the injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony that is the direct result of an underlying health factor, then the exclusion will not apply;
- Services provided remotely by telephone if the service is not appropriate to be performed remotely;
- Expenses for preparing medical reports/medical records, bills, disability/sick leave claim forms; mailing, shipping, or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailing charges, prescription refill charges, automotive forms/interest charges, late fees, mileage costs, Provider administration fees, concierge/retainer agreement/membership fees, and/or photocopying fees;
- Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by an employer, or if benefits are otherwise provided under this Plan or any other plan that an employer contributes to or otherwise sponsors;
- Expenses for services or supplies for which a third party is required to pay;

- Educational services. Even if they are required because of an injury, illness or disability of a Enrollee, the following expenses are not covered by the Plan: educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory aids, speech aids/synthesizers, programs to assist with auditory perception or listening/learning skills, vision therapy, auditory or auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc., special education and associated cost in conjunction with sign language education for an Enrollee or family members and implantable medical identification/tracking devices. This exclusion does not apply to approved diabetes, cardiac rehabilitation, home hemodialysis and hemophilia, or smoking cessation education services;
- Expenses that exceed any Plan benefit, including but not limited to the annual maximum Plan benefits and lifetime maximum Plan benefits;
- Any portion of the expenses for covered medical services or supplies that are determined to exceed the Allowed Amount;
- Expenses for services payable under any health care contract under the coordination of benefits provision of this Plan;
- Services not related to specific diagnosed illness/injury. Expenses for premarital examinations, pre-employment examinations, or for routine or periodic physical examinations unrelated to the existence of a previously diagnosed specific condition, disease, illness, or injury, except as specifically provided for under the Plan;
- Military service-related injury/illness. If an Enrollee under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility for a military service-related illness or injury, benefits are not payable by the Plan;
- Modifications of homes or vehicles. Expenses for construction or modification to a home, residence, or vehicle required as a result of an Injury, Illness or Disability of an Enrollee, including but not limited to construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc., except as specifically provided under the Plan;
- No-Cost services. Expenses for services rendered or supplies provided for which an Enrollee is not required to pay, or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan;

- Expenses that are determined by the Carrier to be unreasonable;
- Travel and related expenses. Expenses for and related to travel or transportation (including lodging and related expenses) of a Provider, Enrollee, or family member of an Enrollee, unless those expenses are covered under the Plan's ambulance services;
- Personal comfort items. Expenses for Enrollee convenience, including, but not limited to, care of family members while the Enrollee is confined to a Hospital or other health care facility or to bed at home, guest meals, television, DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, housecleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.;
- Failure to comply with medically appropriate treatment. Expenses incurred by an Enrollee as a result of failure to comply with medically appropriate treatment, as determined by the Carrier;
- Expenses incurred by an Enrollee during travel if a doctor or other Provider has specifically advised against such travel because of the health condition of the Enrollee;
- Telephone calls. Expenses for any and all telephone calls that do not meet Plan criteria to be a separately payable service. Examples of such uncovered calls include, but are not limited to:
    - Call with a representative of the Plan;
    - Calls between two or more Providers (not involving the Enrollee) for the purposes of care coordination;
    - Calls between a Provider and the Enrollee's family that are not discussing the Enrollee's condition or plan of care;
    - Calls solely to note the results of diagnostic testing (without further medical advice); and
    - Calls solely to describe an action taken by the Provider, such as submitting a Prior Authorization or referral, without further medical advice.
- Expenses for services of private duty nurses. Private duty nursing means nursing care that is privately contracted by, or on behalf of, an Enrollee with a nurse, or agency, independent of this Plan;
- Expenses for job training or vocational rehabilitation; and
- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums and /or any other facility for physical fitness programs, including exercise equipment.

VII. NON-MEDICARE PRESCRIPTION DRUG PLAN

This section explains Your prescription drug coverage when You are not eligible for Medicare drug coverage under the Plan.

To get a complete understanding of Your benefits, it is important that You also review the Schedule of Benefits, Health Care Benefits Summary, and Benefit Highlights Letter.

1. Prescription Drug Covered Expenses

You have prescription drug coverage. Covered prescription drugs include drugs approved by the 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.

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 generally 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, whenever possible 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 drug.

When You receive a brand name medication, especially a non-preferred drug You generally pay more. Your physician or pharmacist can assist You in substituting generic medications when appropriate. Generic drugs generally have a lower Copayment than brand name drugs.

You are encouraged, where possible and appropriate, to ask Your Provider to prescribe generic drugs, which will be the lowest cost to You.

If Your doctor has not indicated "Dispense As Written" or DAW on Your prescription, it will automatically be filled with a generic drug (when available). If You still request the brand-name drug and it is approved, You will pay a higher Copayment.

Biologic drugs and biosimilars are handled in a similar way as brand and generic drugs. 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.

5. Maintenance Drug List (MDL)

Maintenance prescription 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 and the Plan will cover only the first three prescription drug fills at Your retail pharmacy (the initial fill and two refills). If You choose to continue to fill the MDL prescription at a Participating Retail Pharmacy, You may be charged 100% of the drug cost. If You choose to fill any MDL prescriptions at a Non-Participating Retail Pharmacy, You may be charged 100% of the drug cost.

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 mail order pharmacy through the PBM 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 the mail order pharmacy through the PBM.

Special rules may apply if You reside in a long-term care or assisted living facility. Contact the PBM, whose number is on the back of Your pharmacy benefit ID card, 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 at a Participating Retail Pharmacy. 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 doctor 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 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 at the pharmacy and obtain a prescription receipt that You can submit to the PBM for reimbursement. You will be responsible for the difference in cost between the amount charged and the Allowed Amount, after deducting Your retail Copayment (in other words, the PBM will reimburse You the Allowed Amount minus Your retail 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. You can expect to receive Your first

filled prescription about two weeks from the time the PBM receives Your prescription. If You need a medication right away, make sure Your doctor 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. Please contact the PBM to coordinate how to fill the second 90-day prescription through the PBM's mail order pharmacy. Refills can be ordered using the PBM's website, calling the PBM, using the PBM's mobile application, 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. Specialty Pharmacy

You may be prescribed a specialty medication. Specialty medications are injectable, infused, inhaled, or oral products with unique handling or dosing requirements. Many of these specialty medications are not available through a retail pharmacy but are available through a designated specialty pharmacy. In most situations, after You pay the required Copayment, the specialty pharmacy will ship the specialty drug and any required supplies You need for Your specialty medication directly to Your home. Generally, specialty medications are limited to a 30-day supply.

9. 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 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, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

b. Dose Duration Limits

For certain drugs, the Plan may cover only a specific dose of a drug over a specific period of time.

c. Dose Optimization/Tablet consolidation

Sometimes the PBM will notify Your Provider of an opportunity to reduce the number of dosage units dispensed, while still fully satisfying Your therapeutic needs. For example, tablet consolidation means that You take one tablet of a higher strength daily rather than two tablets of a lower strength daily (same total daily dose).

d. Prior Authorization

The Plan requires a review by one of its pharmacists to determine if certain drugs qualify for coverage under the Plan. This is called Prior Authorization. Prior authorization may be used to confirm the diagnosis for which the drug is prescribed. If Your Provider prescribes a drug that requires a Prior Authorization, the PBM will contact Your Provider to complete the Prior Authorization review. If Your Provider prescribes a drug for Off-Label Use, the drug is generally not covered by the Plan.

e. 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.

10. Prescription Drug Coverage

The following prescription drugs are generally covered, subject to the other limitations included in this SPD:

- Federal Legend Drugs: Any medicinal substances that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription";
- Compound Drugs: Some compound drugs are covered under Your Plan. Please contact the PBM to determine if a particular compound drug is covered.
- Insulin, including syringes and needles dispensed with self-administered insulin; and
- Vaccinations, immunizations, and inoculations or preventive injections, as determined appropriate by the Plan. Some vaccinations, immunizations, and inoculations may also be covered under the medical benefit when delivered in an office setting. Certain injections may be covered under either medical or the drug benefit and may therefore have different cost-sharing.

11. Prescription Drug Exclusions

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

- Drugs not approved by the FDA, including Off-Label Use (except that prescription drugs for Medically Necessary treatment of gender dysphoria are covered and certain other exceptions may be permitted if the use of the drug is supported by the major drug compendia or authoritative medical literature);

- Drugs available over-the-counter without a prescription (exception: insulin is covered);
- Drugs requiring a prescription by state law, but not by federal law;
- 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) (note that treatment of gender dysphoria will not be considered a cosmetic purpose);
- Medical devices or appliances; check Your benefits under Your medical plan.
- Charges for more refills than Your doctor specifies or refills after a year from the original date of the prescription;
- Drugs not on the Plan's Formulary;
- Diabetic supplies covered under Your Carrier's Durable Medical Equipment (DME) Program (e.g., home blood glucose monitor, test strips);
- Drugs used for treatment of sexual/erectile dysfunction or inadequacy;
- Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs, and minerals, whether they can be purchased over-the-counter or require a prescription (exception examples: foods and nutritional supplements provided during covered hospitalization and via intravenous care at home, prenatal vitamins, and vitamins or minerals requiring a prescription and used for treatment or prevention of a documented medical condition are covered);
- Naturopathic, naprapathic, or homeopathic services and substances;
- Drugs to enhance athletic performance, such as anabolic steroids;
- Dental products such as fluoride preparations;
- Cosmetic skin treatment products (exception: Retin-A and Accutane, which are payable to age 26 when Medically Necessary);
- Weight control or anorexiants (e.g., Meridia, Xenical);
- The charge for any medication for which the Enrollee is entitled to benefits without charge from municipal, state, or federal programs;
- Compound Drugs: Some compound drugs are covered under Your Plan. Please contact the PBM to determine if a particular compound drug is covered.
- Take-home drugs or medicines provided by a Hospital, emergency room, ambulatory surgical facility/center, Provider's office, or other health care facility.

VIII. ADDITIONAL BENEFITS FOR ALL MEMBERS

A. DENTAL COVERAGE

The benefits of the Dental Plan are summarized in this SPD and in either the Schedule of Benefits, the Health Care Benefit Summary, and/or the annual Benefit Highlights Letter. It is important to review all such documents when evaluating benefit coverage.

The coverage offered under the Dental Plan has two levels of In-Network Providers (PPO Dentists and Premier Dentists), with PPO Dentists having lower cost-sharing, and also Out-of-Network Providers. By going to a PPO Dentist, You will have the lowest cost-sharing. If You choose a Premier Dentist or an Out-of-Network Provider, You will have higher cost-sharing. A summary of the benefits and applicable cost-sharing is available in the attached Schedule of Benefits.

1. Covered Dental Benefits

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; and
- Orthodontic services if treatment begins before age 19.

2. Dental Coverage Limitations and Exclusions

Certain limitations and exclusions apply to the dental coverage from the Plan. This dental coverage is subject to certain lifetime and annual maximums maintained by the dental Carrier. You should contact the dental Carrier for a full list of these exclusions and limitations. In addition to other Plan exclusions, dental coverage is subject to the following exclusions:

- Expenses for dental services or dental prosthetics or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body;
- Expenses for the diagnosis, treatment or prevention of, or for orthognathic services/surgery for treatment of jaw joint or jaw hinge problems, including related

masticatory problems, prognathism, retrognathism, and Temporomandibular Joint (TMJ) Dysfunction or Syndrome; and

- Expenses for oral surgery to remove teeth including wisdom teeth, gingivectomies, treatment of dental abscesses, and root canal (endodontic) therapy.

B. VISION COVERAGE

The benefits of the Vision Plan are summarized in this SPD and in either the Schedule of Benefits, the Health Care Benefit Summary, and/or the annual Benefit Highlights Letter. It is important to review all such documents when evaluating benefit coverage.

The coverage offered under the Vision Plan has In-Network Providers (generally at lower cost-sharing) and also Out-of-Network Providers (generally at higher cost-sharing). A summary of the benefits and applicable cost-sharing for In-Network Providers is provided in the attached Schedule of Benefits.

1. Covered Vision Benefits

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

- Annual routine vision exam;
- Standard lenses;
- Standard frames; and
- Contact lens evaluation, fitting, and follow-up care.

2. Vision Coverage Limitations and Exclusions

Certain limitations and exclusions apply to the vision coverage from the Plan. This vision coverage is subject to certain lifetime and annual maximums, as well as limits on the type or kinds of lenses and frames provided. The Plan sets a dollar limit on each of the covered services in the vision benefit. Expenses beyond that dollar limit or "allowance" are the responsibility of the Enrollee. You should contact the Vision Carrier for a full list of these exclusions and limitations. In addition to other Plan exclusions, vision coverage does not cover vision therapy (orthoptics) and supplies.

C. HEARING COVERAGE

The benefits of the Hearing Plan are summarized in this SPD and in either the Schedule of Benefits, the Health Care Benefit Summary, and/or the annual Benefit Highlights Letter. It is important to review all such documents when evaluating benefit coverage.

To get coverage under the Hearing Plan, You must receive services from In-Network Providers.

1. Hearing Coverage

The Hearing 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 Carrier using the contact information at the back of this SPD. The Hearing Carrier will guide You through the selection of an appropriate Provider and help You ensure You receive 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.

2. Hearing Coverage Limitations and Exclusions

Certain limitations and exclusions apply to the hearing coverage from the Plan. You should contact the Hearing Carrier for a full list of these exclusions and limitations. In addition to other Plan exclusions, hearing coverage is subject to the following exclusions:

- Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices, including implantable hearing devices (except for Medically Necessary cochlear implants, which are covered); and
- Special education and associated costs in conjunction with sign language education for an Enrollee or family members.

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

D. OVER-THE-COUNTER BENEFIT COVERAGE

This benefit is not available to Enrollees in the non-Medicare HMO plans or the Humana Commercial plan.

This benefit offered by the Plan provides an annual allowance that may be used to purchase eligible over-the-counter drugs and non-prescription items.

The benefits of the Over-the-Counter coverage are summarized in this SPD, the Schedule of Benefits, the Health Care Benefit Summary, and/or the annual Benefit Highlights Letter. It is important to review all such documents when evaluating benefit coverage.

If You are enrolled in more than one plan with the Trust under which You are eligible for an Over-the-Counter benefit allowance, You are eligible to receive only one annual allowance under the Plan's over-the-counter benefit. If the annual allowance under the two plans in which You are enrolled is different, You will be eligible to receive the higher annual allowance.

The Plan will cover the over-the-counter benefits set forth in the catalog provided by the Carrier.

IX. NON-MEDICARE PLAN RULES

NOTE: If You have a claim or appeal involving a non-Medicare HMO plan, 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 ensures that You and Your Provider are not paid twice for the same benefit.

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

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. When the Plan is the secondary plan, it will not apply Prior Authorization requirements or certain other requirements (for example, requirement to get a second opinion or requirement to obtain services from an In-Network or Participating Provider) that are usually required for the Plan to cover the item or service when the Plan is the primary plan.
- 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 the Plan.

If You are covered by both the Plan and Medicaid, the 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 COB 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 Co. Mary is also listed as a Dependent Spouse under George's Plan through the Trust.
- When Mary has services provided, her retiree health plan (ABC Co.) 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.

In another example, Mary receives a service that both ABC Co. and the Trust would cover. If Mary only had her ABC Co. 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 Co., would pay if that were the only coverage she had:

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

Second, the plan for Mary's husband George, the Trust Plan, will cover some of her remaining cost because she is enrolled as a Dependent Spouse under George's coverage. 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.

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

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.

3. Enrollee COB-Related Obligations

Enrollees must provide the Carrier any information necessary for the purpose of administering these COB rules. Primary Enrollees must provide to the Plan the Social Security Numbers and Medicare Beneficiary Identification number, if applicable, of all Dependents. If the Dependent has not been assigned a Social Security Number at the time of the enrollment, a Social Security Number must be obtained promptly and reported to the Plan. If You do not timely provide this information to the Plan, the Plan may cancel the Dependent's coverage.

4. Release of Information

The Plan and/or the Carrier may release information to other entities that is needed to administer claims under these COB rules. The Plan and/or the Carrier may also obtain information necessary to determine priority under these COB rules without consent of any person or Enrollee. If You do not timely provide the information the Plan and/or the Carrier requests, the Plan may refuse to pay benefits on Your behalf until You provide the requested information.

The Plan and/or the Carrier may participate in organizations that are established to help the COB process work and may exchange information relating to Enrollees for such purposes. The Plan requires such organizations to agree not to release any information obtained, except to help the COB process work.

5. Right of Recovery

If the Plan pays more than it should have paid under these COB rules, this Plan may recover the excess amount it paid from the person or entity who received the excess payment, including from insurance companies, other plans, or other individuals and organizations. The Plan can recover the reasonable cash value of any excess benefits provided in the form of services.

X. CLAIMS AND APPEALS

A. CLAIMS AND APPEALS PROCESS FOR NON-MEDICARE HMO, MEDICARE ADVANTAGE HMO, MEDICARE ADVANTAGE PRESCRIPTION DRUG HMO OR PPO, AND MEDICARE PRESCRIPTION DRUG PLAN

Claims and appeals under the non-Medicare HMO, MA HMO, MA-PD HMO or PPO, and Medicare Prescription Drug plans are decided by the applicable Carrier. Claims and appeals for the non-Medicare HMO are decided in accordance with the Carrier's reasonable procedures, as required by ERISA. Claims and appeals for the MA HMO, MA-PD HMO or PPO, and Medicare Prescription Drug Plan are decided by the Carrier's reasonable procedures, as required by ERISA, which follow guidance issued by the Centers for Medicare & Medicaid Services. In making determinations on claims for benefits, including the review of appeals of claim denials, the Carrier has full authority to interpret and apply, in its discretion, the terms of the Plan, including ambiguous terms. The decision of the Carrier is final and binding. The voluntary appeals process described elsewhere in this SPD is not offered for the plans described in this Section X(A) of this SPD. Claims and appeals procedures for these plans are summarized in Your Evidence of Coverage or Certificate of Coverage provided by the Carrier.

B. CLAIMS PROCESS FOR ECP, TCN, HUMANA COMMERCIAL, DENTAL, VISION, HEARING, AND NON-MEDICARE PRESCRIPTION DRUG PLANS

This section covers the claims process for the ECP, TCN, Humana Commercial, Dental, Vision, Hearing, and non-Medicare Prescription Drug plans. Claims for these plans are also decided by the applicable Carrier, in accordance with the Carrier's reasonable procedures, as required by ERISA.

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

1. What is a "Claim"?

A claim is a request for benefit or service to be covered by the Plan. To trigger the Plan's claims processing procedures, a claim must:

- Be written or be electronically submitted in accordance with the Electronic Data Interchange (EDI) standards of HIPAA (except that the Plan accepts verbally submitted Urgent Care Claims);
- Be received by the Trust, the applicable Carrier, or other delegate;

- Identify a specific Enrollee;
- Identify a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (additionally, post-service claims must include an itemized detail of charges);
- Identify the Provider's name, address, phone number, professional degree or license and federal tax identification number (TIN); and
- If another plan is the primary payer, include a copy of the other plan's Explanation of Benefits (EOB) statement.
- Be timely submitted to the Plan, the applicable Carrier, or other delegate, unless the individual filing the claim can show that it was not possible to file the claim within the required time period and that the claim was filed as soon as was reasonably possible.
- If the claim is under the TCN plan, first be submitted to Medicare before being submitted to a Carrier.

Example 1: George visits his doctor. The doctor files the claim with the Plan on George's behalf.

2. What is not a Claim

A request is not a Claim if it is:

- Not made in accordance with the Plan's claims filing procedures;
- Made by someone other than the Enrollee, the Enrollee's Authorized Representative, or a Provider who is treating the Enrollee;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is covered or the estimated allowed cost for a service;
- For prior approval of an item or service, if it is for an item or service for which the Plan does not require prior approval;
- An eligibility inquiry;
- A presentation of a prescription to a pharmacy that the pharmacy or pharmacy benefit manager denies if the pharmacy or pharmacy benefit manager has no discretion to make decisions on claims. After the denial by the pharmacy, an Enrollee or his or her Authorized Representative may file a claim with the applicable Carrier.

3. How to File a Claim

You should present Your health care identification card whenever You go to a Hospital, outpatient treatment facility, doctor, or other Provider 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 file a claim on Your behalf directly with the Carrier and be paid directly by the Carrier. Contact information for Your Carrier, including its address, is included on Your health care identification card, as well as at the end of this SPD.

Medical

If the Provider does not file a claim on Your behalf directly with the Carrier, You may have to pay that Provider up front for the health care services they provided. If this happens, You should submit a claim directly to the Carrier at the address that is on Your health care identification card as soon as reasonably possible (by no later than the time period described in the next Section X(B)(4)) so that You can be reimbursed for health care items and services covered by the Plan. If You have not already paid the Provider in full, be sure to immediately forward payment to the Provider after You receive reimbursement from the Carrier. If Your Provider does not file a claim on Your behalf directly with the Carrier, You may wish to ask why not.

Pharmacy

When You present Your prescription drug identification card at a pharmacy and ask for a fill of a prescription, that is not, technically, filing a claim. A claim is only filed when You, or the pharmacy on Your behalf, asks the Carrier to pay for a prescription fill. Most of the time, the pharmacy files a claim on Your behalf with the Carrier for each prescription fill.

Example 1:
George visits his In-Network Provider. The person at the reception area makes a copy of his health care identification card. After George's visit with the doctor, the Provider's office files a claim with the Plan for the office visit. The Provider 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 prescription. The pharmacy files the claim with the Carrier for the prescription drug fill.

Example 2:
George goes to get a prescription filled at his pharmacy. The drug is not on the Plan's Formulary so may not be covered under the Plan, but George decides he wants the drug anyway. He pays for it out of pocket at the pharmacy. George then files a claim with the Carrier for reimbursement of the prescription drug fill. If the Carrier denies the claim (which is likely because it is not for a drug on the Plan's Formulary), George will have the option to appeal.

4. Deadline for Filing Claims

The timeframe required for filing claims may vary based on whether You, the Provider, or the facility submits the claim, the type of plan in which You are enrolled, and the type of item or service being billed on the claim.

ECP and Humana Commercial Claims:

a. Claims filed by You

You must file a claim no later than 24 months from the date the item or service was provided, except that claims for home infusion therapy must be filed no later than 15 months from the date the item or service was provided.

b. Claims filed by Providers or Facilities

Claims filed by Providers for professional items or services must be filed no later than the end of the calendar year after the year the item or service was provided. Claims filed by Providers or facilities for facility items or services (like inpatient hospitalization) must be filed no later than 365 calendar days after the item or service was provided. 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.

c. TCN Claims

All claims, regardless of who files the claim and the item or service being billed, must filed no later than 24 months from the date the item or service was provided.

d. Dental and Hearing Claims

All claims, regardless of who files the claim, must be filed no later than 365 days from the date the item or service was provided.

e. Vision Claims

Claims filed by members must be filed no later than 365 days from the date the item or service was provided.

5. Claim Denials

A denial of a claim might also be called an "claim denial" or an "adverse determination".

6. Notice of Claim Decision

The Carrier will give You written notice of whether a claim was approved or denied. Usually, this will take the form of the Explanation of Benefits, which is mailed to Your home, and it will describe:

- What was covered and what was not;
- When an item is not covered:
  - The reasons for the denial;
  - The specific provisions of the Plan on which the denial is based;
  - Whether any additional information is required from You and why such information is needed; and
  - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, the notice will give You 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 claim denial. A copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request. If the claim denial is based on Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, You will be provided either an explanation of the scientific or clinical judgment used to make the decision, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
  - An explanation of the claims review procedure and the applicable time limits, including a statement concerning Your right to bring a civil action under Section 502(a) of ERISA; and
  - If the claim denial was of an urgent care claim, a description of the expedited review process applicable to such claims. In the case of an urgent care claim, the notice of the benefit determination may be made verbally, if the Carrier gives You a written notice within three calendar days after the verbal notification is provided.

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 D below in this SPD). 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.

7. Types of Claims and Deadlines for Decisions

a. 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 "Prior Authorization," 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 for coverage. This 15-day time period may be extended one time by the Carrier for up to 15 additional calendar days, if the Carrier: (i) determines that such an extension is necessary due to matters beyond the control of the Plan; and (ii) notifies You, prior to the expiration of the initial 15-day time period of the circumstances requiring the extension of time and the date by which the Carrier expects to render a decision. If the extension is necessary because the information necessary to decide the claim was not timely submitted, then the notice of extension must specifically describe the information required. You have at least 45 calendar days from receipt of the notice to provide the specified information. The extended time period for making the claim decision is paused starting on the date on which the Carrier sends You the notice of extension until the earlier of: (i) the date on which You respond to the request for additional information; or (ii) 45 days has elapsed.

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. Before performing the surgery, the surgeon would file a pre-service claim with the Plan to make sure the Plan will cover the surgery.

b. Urgent Care Claims

An urgent care claim is any pre-service claim for medical care or treatment or a prescription drug, which, if determined within the typical time periods for making decisions on pre-service claims:

1. Would seriously jeopardize Your life or health or ability to regain maximum function if normal time periods to decide pre-service claims 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.

Special rules apply to these claims requesting urgent medical care or an urgent prescription drug fill. These rules require the Carrier or PBM to notify You of the decision on an urgent care claim as soon as possible, taking into account the urgency of the medical

circumstances, but no later than 72 hours after the Carrier receives the request for coverage, unless the information necessary to decide the claim was not timely submitted.

If the information necessary to decide the claim was not timely submitted, the Carrier will notify You as soon as possible, but no later than 24 hours after the Carrier receives the claim by the Plan, of the specific information necessary to decide the claim. You will be given a reasonable amount of time, but not less than 48 hours, to provide the information requested. The Carrier will notify You of the Plan's decision on the urgent care claim as soon as possible, but in no case later than 48 hours after the earlier of: (i) the Carrier's receipt of the specified information; or (ii) the end of the period afforded You to provide the specified additional information.

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 claim with the Plan 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 D below in this SPD.

c. Post-service Claims

Post-service claims are claims for medical care or treatment or a prescription drug that have already been provided. In the case of a post-service claim, the Carrier will notify You about Your claim status within a reasonable period of time, but no later than 30 days after the Carrier receives the request for coverage.

This 15-day time period may be extended one time by the Carrier for up to 15 additional calendar days, if the Carrier: (i) determines that such an extension is necessary due to matters beyond the control of the Plan; and (ii) notifies You, prior to the expiration of the initial 15-day time period of the circumstances requiring the extension of time and the date by which the Carrier expects to render a decision. If the extension is necessary because the information necessary to decide the claim was not timely submitted, then the notice of extension must specifically describe the information required. You have at least 45 calendar days from receipt of the notice to provide the specified information. The extended time period for making the claim decision is paused starting on the date on which the Carrier sends You the notice of extension until the earlier of: (i) the date on which You respond to the request for additional information; or (ii) 45 days has elapsed.

d. Concurrent Claims

A concurrent claim is a claim to extend an ongoing course of treatment over a period of additional time (like more days in the Hospital) or additional number of treatments (like 10 more physical therapy visits) beyond what was already approved by the Plan. In the case

of a concurrent claim, the Carrier will notify You of Your claim status as soon as possible, taking into account the urgency of the medical circumstances, and in time to allow You to have an appeal decided before the treatment is reduced or terminated, if the claim is received by the Carrier at least 24 hours before the treatment is scheduled to reduce or terminate.

Example:
Lynn has surgery after her bad knee gives out on her completely. The Plan approves her to receive 10 visits of physical therapy to help her recover. After eight visits, her physical therapist determines she will need more than 10 physical therapy visits to help her knee become functional again (i.e., a total of 15 physical therapy visits are now needed). The physical therapist's claim for an additional five physical therapy visits is a concurrent claim because the Plan already approved Lynn's ongoing course of treatment (initial 10 physical therapy visits) and the physical therapist sought an extension of that benefit (five more physical therapy visits).

e. Eligibility Determination Claims

An eligibility determination claim is a claim to determine Your eligibility under the Plan. An eligibility determination claim is subject to the following rules:

- An eligibility determination claim must be filed in the form, time and manner determined by the Plan.

After an eligibility determination claim has been filed with the Plan, the Plan will notify the individual filing the claim of its eligibility determination (including if it denies the claim) within a reasonable period of time, but no later than 45 calendar days after receipt of the claim by the Plan or its delegate.

- This period may be extended two times for 30 days each by the Plan for up to a total of 60 days, if the Plan or its delegate determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the individual who filed the claim, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the individual who filed the claim to submit the information necessary to decide the claim, then:
- The notice of extension shall specifically describe the required information;
- The individual who filed the claim will be given at least 45 days from receipt of the notice to provide the required information; and
- The period for making a decision on the eligibility determination claim will be put on hold, starting on the date the notice of extension is sent to the individual who filed the eligibility determination claim and continuing until the date on which that individual responds to the request for additional information.

	Pre-service Claims	Urgent Care Claim	Post-Service Claim	Concurrent Claim	Eligibility Determination Claim
Plan must make **an initial claim decision** as soon as possible but no later than:	15 calendar days after receipt of the claim	72 hours after receipt of the claim	30 calendar days after receipt of the claim	Before the benefit is reduced or treatment terminated, if claim is received at least 24 hours before benefit is scheduled to reduce or terminate	45 calendar days after receipt of the claim
Extension permitted during initial claim decision, if the Carrier notifies You before the original decision timeframe ends and the extension is needed for matters beyond the control of the Carrier?	15 calendar days	No	15 calendar days	No	Up to 60 days

8. 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 provided, 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 Trust may terminate coverage under the Plan for any act or omission by a Retiree, surviving Spouse, surviving Same-Sex Domestic Partner, 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.

C. APPEALS PROCESS FOR ECP, TCN, HUMANA COMMERCIAL, DENTAL, VISION, HEARING, OVER-THE-COUNTER BENEFIT, NON-MEDICARE PRESCRIPTION DRUG PLANS, AND ELIGIBILITY DETERMINATIONS

This section covers the claim appeals process for ECP, TCN, Humana Commercial, Dental, Vision, Hearing, Over-the-Counter Benefit, and Non-Medicare Prescription Drug plans, and eligibility determinations. Appeals for the ECP, TCN, Humana Commercial, Dental, Vision, Hearing, and Non-Medicare Prescription Drug plans are decided by the applicable Carrier, in accordance with the Carrier's reasonable procedures as required by ERISA. Appeals for the Over-the-Counter Benefit plan are decided by the Trust, in accordance with the Trust's reasonable procedures as required by ERISA. Appeals for eligibility determinations are decided by the Plan, in accordance with the Plan's reasonable procedures as required by ERISA. If You are enrolled in the ECP, TCN, Humana Commercial, Dental, Vision, Hearing, Over-the-Counter Benefit, or the non-Medicare Prescription Drug plan and have exhausted the Carrier's procedures, You may be able to file a voluntary appeal with the Trust. If Your eligibility determination is initially denied by the Plan, You may be able to file a Voluntary Appeal with the Trust. Voluntary appeals are decided by the Trust.

If Your claim is denied in whole or in part, You have the right to file an appeal to have Your claim reviewed to be sure it was decided correctly. 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.

The Plan has given authority to the Carrier to interpret and apply the Plan. The individual(s) at the Carrier who made the initial decision to deny Your claim in whole or in part will not be the same individual(s) who decide Your appeal, nor will those initial decision-makers be the supervisors of those who will decide Your appeal. The individual(s) who decide Your appeal will not give deference or regard to the initial claim denial.

In deciding an appeal of any denied claim 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 a claim denial, without regard to whether the advice was relied upon in making the claim denial; 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 claim denial that is the subject of the appeal, nor a subordinate of any such individual.

1. Claims Appeal Process for ECP, TCN, Humana Commercial, Dental, Vision, and Hearing Plans

You have one level of appeal with the Carrier. You may also have the opportunity to submit a voluntary appeal with the Trust.

2. Level 1 Appeal Process

You have 180 calendar days from the date the claim was initially denied, in whole or in part, to make a written request to the applicable Carrier to have the claim decision reviewed through a level 1 appeal. However, appeals of urgent care claims may be submitted by telephone. If You do not submit a level 1 appeal of the claim decision within 180 calendar days from the date the claim was initially denied, You lose Your right to appeal and the initial decision on the claim is final. As part of the appeal process, You may submit any written comments that may support the claim. A written decision on the request for appeal will be furnished to You as described in the chart below.

To initiate a level 1 appeal 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. 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 may decide to hold one or more hearings before deciding the level 1 appeal. You may, at Your own expense, have an attorney or other representative act on Your behalf, but the Carrier requires a written authorization from You to ensure You have given that representative Your permission to do so.

The Carrier will respond to Your request for review with a written decision on Your level 1 appeal within the applicable timeframe set forth in the chart below, unless they have notified You in writing that they need additional information to complete their review. The notice will describe:

- What was approved and what was denied;
- When an item is denied:
  - The reasons for the denial; and
  - The specific provisions of the Plan on which the denial is based; and
  - Any documents, records, or other information relevant to Your claim for

benefits. A copy of such documents, records, or other information will be provided free of charge to You upon request; and

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, the notice will give You 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 claim denial. A copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request. If the claim denial is based on Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, You will be provided either an explanation of the scientific or clinical judgment used to make the decision, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- An explanation of the voluntary appeal procedures offered by the Trust and Your right to bring a civil action under Section 502(a) of ERISA.

After You receive the Carrier's written notice of whether Your level 1 appeal was approved or denied:

- If You agree with the decision on Your level 1 appeal, it becomes the final determination, and the review ends.
- If You disagree with the decision on Your level 1 appeal, You may then proceed to the voluntary appeal process for most level 1 appeal decisions.

3. Voluntary Appeal Process

- If You disagree with the decision of the Carrier's claim denial after appeal, at Your option, You may file a voluntary appeal with the Trust. You must file a voluntary appeal within 180 days of the date of the Carrier's denial of Your level 1 appeal. 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. The Carrier's appeal determination completes the appeal process, and You are not required to file a voluntary appeal.

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

You can elect to file a voluntary appeal with the Trust under the voluntary appeal process only after exhaustion of the appeal process described above. To file 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

The Trust's decisions on voluntary appeals are final.

Level 1 and Voluntary Appeals for ECP, TCN, Humana Commercial, Dental, Vision, and Hearing Claims				
	Pre-service Claims	**Urgent Care Claim**	**Post-Service Claim**	**Concurrent Claim**
Level 1 Appeal request must be submitted to the Carrier within:	180 calendar days of initial claim decision	180 calendar days of initial claim decision	180 calendar days of initial claim decision	180 calendar days of initial claim decision
Carrier must make **Level 1 Appeal decision** and notify Enrollee of decision as soon as possible but no later than:	30 calendar days after Carrier's receipt of appeal	72 hours after Carrier's receipt of appeal	30 calendar days after Carrier's receipt of appeal	72 hours after Carrier's receipt of appeal if for urgent care, otherwise 30 calendar days after Carrier's receipt of appeal
Voluntary Appeal request must be submitted to the Trust within:	180 calendar days of Carrier's Level 1 appeal denial	180 calendar days of Carrier's Level 1 appeal denial	180 calendar days of Carrier's Level 1 appeal denial	180 calendar days of Carrier's Level 1 appeal denial
Trust will make a **Voluntary Appeal decision** and notify Enrollee of decision as soon as possible				

4. Over-the-Counter Benefit Claims Appeal Process

You have one level of appeal with the Trust. You may also have the opportunity to submit a voluntary appeal with the Trust.

a. Level 1 Appeals Process

For appeals of claims, You have 180 calendar days from the date the claim was initially denied, in whole or in part, to make a written request to the Trust to have the claim decision reviewed through a level 1 appeal. If You do not submit a level 1 appeal of the claim decision within 180 calendar days from the date the claim was initially denied,You lose Your right to appeal and the initial decision on the claim is final. As part of the appeal process, You may submit any written comments that may support the claim. A written decision on the request for appeal will be furnished to You.

To initiate a level 1 appeal review, You or Your Authorized Representative must send the Trust a written statement explaining why You disagree with its determination. Please include in Your request all documentation, records, or comments You believe support Your position. Mail Your written request for review to the address in the letter the Trust sent notifying You that they have not approved a benefit You are requesting. The Trust will respond to Your request for review with a written decision within 45 days from its receipt of Your appeal, unless it has notified You in writing that it needs additional information to complete its review or that certain special circumstances apply that give the Trust an additional 45 days to respond with a written decision.

b. Voluntary Appeal Process

If You disagree with the decision of the Trust's claim denial after appeal, at Your option, You may file a voluntary appeal with the Trust. You must file a voluntary appeal within 180 days of the date of the Trust's denial of Your level 1 appeal. 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. The Trust's determination completes the appeal process, and You are not required to file a voluntary appeal. Whether or not You submit Your denied claim for voluntary appeal will not affect the other benefits under the Plan.

You can elect to file a voluntary appeal with the Trust under the voluntary appeal process only after exhaustion of the appeal process described above. To file 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

The Trust's decisions on voluntary appeals are final.

5. Non-Medicare Prescription Drug Claims Appeal Process

You have one level of appeal for non-Medicare prescription drug claims. You may also have the opportunity to submit a voluntary appeal with the Trust.

a. Level 1 Appeals Process

For appeals of claims for prescription drugs, You have 180 calendar days from the date the claim was initially denied, in whole or in part, to make a written request to the applicable Carrier to have the claim decision reviewed through a level 1 appeal. However, appeals of urgent care claims may be submitted by telephone. If You do not submit a level 1 appeal of the claim decision within 180 calendar days from the date the claim was initially denied, You lose Your right to appeal and the initial decision on the claim is final. As part of the appeal process, You may submit any written comments that may support the claim. A written decision on the request for appeal will be furnished to You as described in the chart below.

To initiate a level 1 appeal 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. 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 with a written decision within 30 days, unless they have notified You in writing that they need additional information to complete their review. The Carrier may decide to hold one or more hearings before deciding the level 1 appeal. You may, at Your own expense, have an attorney or other representative act on Your behalf, but the Carrier requires a written authorization from You to ensure You have given that representative Your permission to do so.

The Carrier will respond to Your request for review with a written decision on Your level 1 appeal within the applicable timeframe set forth in the chart below, unless they have notified You in writing that they need additional information to complete their review. The notice will describe:

- What was approved and what was denied;
- When an item is denied:
  - The reasons for the denial; and
  - The specific provisions of the Plan on which the denial is based; and
  - Any documents, records, or other information relevant to Your claim for benefits. A copy of such documents, records, or other information will be provided free of charge to You upon request; and

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, the notice will give You 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 claim denial. A copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request. If the adverse determination is based on Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, You will be provided either an explanation of the scientific or clinical judgment used to make the decision, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- An explanation of the voluntary appeal procedures offered by the Trust and Your right to bring a civil action under Section 502(a) of ERISA.

After You receive the PBM's written notice of whether Your level 1 appeal was approved or denied:

- If You agree with the decision on Your level 1 appeal, it becomes the final determination, and the review ends.
- If You disagree with the decision on Your level 1 appeal, You may then proceed to the voluntary appeal process for most level 1 appeal decisions.

b. Voluntary Appeal Process

If You disagree with the decision of the PBM's claim denial after Level 2 appeal, at Your option, You may file a voluntary appeal with the Trust. You must file a voluntary appeal within 180 calendar days of the date of the PBM's denial of Your level 2 appeal. 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 PBM's final determination completes the appeal process and You are not required to file a voluntary appeal.

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

You can elect to file a voluntary appeal with the Trust under the Voluntary Appeal Process only after exhaustion of the appeal process described above. To file 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

The Trust's decisions on voluntary appeals are the final step of the Plan's appeal process. Please see Section XI Information For All Enrollees, sub-section E(4).

6. Eligibility Determination Appeal Process

This is the process to use if You want to appeal the Plan's decision about whether You or a Dependent are eligible to enroll in a plan or receive the Over-the-Counter Benefit.

You have one level of appeal with the Plan. You may also have the opportunity to submit a voluntary appeal with the Trust.

a. Level 1 Appeals Process

For appeals of eligibility determinations, You have 180 calendar days from the date the eligibility determination claim was initially denied, in whole or in part, to make a written request to the Plan to have the eligibility determination claim decision reviewed through a level 1 appeal. If You do not submit a level 1 appeal of the eligibility determination claim decision within 180 calendar days from the date the claim was initially denied, You lose Your right to appeal and the initial decision on the claim is final. As part of the appeal process, You may submit any written comments that may support the claim. A written decision on the request for appeal will be furnished to You.

To initiate a level 1 appeal review, You or Your Authorized Representative must send the Plan a written statement explaining why You disagree with its determination. Please include in Your request all documentation, records, or comments You believe support Your position. Mail Your written request for review to the address in the letter the Plan sent notifying You that they have not approved a benefit You are requesting. The Plan will respond to Your request for review with a written decision within 45 days from its receipt of Your appeal, unless it has notified You in writing that it needs additional information to complete its review or that certain special circumstances apply that give the Plan an additional 45 days to respond with a written decision.

b. Voluntary Appeal Process

If You disagree with the decision of the Plan's eligibility determination claim denial after appeal, at Your option, You may file a voluntary appeal with the Trust. You must file a voluntary appeal within 180 days of the date of the Plan's denial of Your level 1 eligibility

determination appeal. The voluntary appeal process is provided to You so that the Plan can ensure consistent application of its rules. Between when Your eligibility determination claim was first decided and when it is reviewed in a voluntary appeal, the Plan might consider changes in generally accepted medical standards. The Plan's determination completes the appeal process, and You are not required to file a voluntary appeal.

Whether or not You submit Your denied eligibility determination claim for voluntary appeal will not affect the other benefits under the Plan.You can elect to file a voluntary appeal with the Trust under the voluntary appeal process only after exhaustion of the appeal process described above. To file 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

The Trust's decisions on voluntary appeals are final.

Level 1, Level 2, and Voluntary Appeals of Claims for Non-Medicare Prescription Drugs					
	Pre-service Claims	**Urgent Care Claim**	**Post-Service Claim**	**Concurrent Claim**	**Eligibility Determination Claim**
Level 1 Appeal request must be submitted to the Carrier within:	180 calendar days of initial claim decision	180 calendar days of initial claim decision	180 calendar days of initial claim decision	180 calendar days of initial claim decision	180 calendar days of initial eligibility determination claim decision
Carrier must make **Level 1 Appeal decision** and notify Enrollee of decision as soon as possible but no later than:	15 calendar days after Carrier's receipt of appeal	72 hours after Carrier's receipt of appeal	30 calendar days after Carrier's receipt of appeal	72 hours after Carrier's receipt of appeal if for urgent care, otherwise 30 calendar days after Carrier's receipt of appeal	45 calendar days after Plan's receipt of appeal
Level 2 Appeal request must be submitted to the Carrier within:	90 calendar days of date of Level 1 appeal denial	N/A	90 calendar days of date of Level 1 appeal denial	90 calendar days of date of Level 1 appeal denial	N/A
Carrier must make a **Level 2 Appeal decision** and notify Enrollee of decision as soon as possible but no later than:	15 calendar days after Carrier's receipt of Level 2 appeal	N/A	30 calendar days after Carrier's receipt of Level 2 appeal	15 calendar days after Carrier's receipt of Level 2 appeal	N/A
Voluntary Appeal request must be submitted to the Trust within:	180 calendar days of Carrier's Level 2 appeal denial	180 calendar days of Carrier's Level 1 appeal denial	180 calendar days of Carrier's Level 2 appeal denial	180 calendar days of Carrier's Level 2 appeal denial	180 calendar days of date of Plan's Level 1 appeal denial
Trust will make a **Voluntary Appeal decision** and notify Enrollee of decision as soon as possible					

7. 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 decision on the voluntary appeal.

8. Authorized Representatives

An Authorized Representative, such as Your adult Dependent or other individual, may file a claim for You and represent You in the appeal process if You are unable to do so Yourself. Contact the Carrier for the form needed to designate an Authorized Representative to act on Your behalf. The Plan may request additional information to verify that this person is authorized to act on Your behalf.

9. 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. Providers are not 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.

XI. 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 Enrollees 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 under the Plan for up to 36 months. COBRA continuation coverage generally is the same health coverage the Dependent 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 continuation of coverage 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 under the Plan for up to 36 months.

1. Plan Notice of Continuation Coverage

The Plan provides a General Notice of COBRA Continuation Coverage Rights (General Notice) to Retirees and Dependents within 90 days of such individuals qualifying for coverage under the Plan, as part of this SPD. Thereafter, the Plan will provide the General Notice upon request.

2. 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 surviving 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.

3. Notify Retiree Health Care Connect to Elect COBRA Continuation Coverage Under the Plan

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 within 14 days of this notification. 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 under the Plan.

If the Plan determines that a Dependent or Same-Sex Domestic Partner is not eligible for continuation coverage, the Plan will provide a notice of ineligibility within 14 days of being notified of a qualifying event or that a Same-Sex Domestic Partner wants to continue coverage under the Plan.

4. 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 under the Plan 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 You or Your Spouse elect this coverage.

5. 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

and will not exceed 102% of the applicable cost (Enrollee cost and Plan cost combined) of providing coverage, as determined by the Trust's actuary.

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 day 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 is considered made on the date 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.

6. 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. If payment is not made within the 30-day grace period, COBRA continuation coverage under the Plan will end. 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.

7. 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 by the required due date plus the grace period;
- 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;
- The Dependent voluntarily cancels coverage; or

- The Dependent becomes entitled to Medicare after the date he or she first elect COBRA Continuation Coverage.

Once coverage under COBRA has been terminated for any reason, it will not be reinstated.

If COBRA Continuation Coverage ends before the end of the 36-month COBRA Continuation Coverage period, the Plan will notify the Dependent that their coverage has ended and the reason why it has ended by sending the Dependent a notice of termination. The Plan will send the notice of termination as soon as possible after the Plan determines that COBRA continuation coverage will be terminated.

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 of 1996 (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 health insurance coverage, read the most recent version of the Plan's "Notice of Privacy Practices" (Notice). 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 protected 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) and Carriers with access to Your protected health 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 allow the Plan to use data related to You as permitted by applicable law. While the Plan may provide services to You when are outside of the United States, to the extent consistent with the terms of the Plan, data privacy laws outside of the United States do not apply to the Plan.

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, the 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 of, and You consent that the only limitations on the use of Your data by the Plan shall be related to the laws of, the United States. 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 United States' statutes or regulations.

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 plan, Your plan may have additional required benefits under applicable State law.

D. 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 the Committee 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 SPD booklet is meant to be an easy-to-understand description of Your benefits. If there is any conflict or discrepancy between this SPD and the Plan Document, the Plan Document controls. If there is any conflict or discrepancy between this SPD and any Schedules of Benefits, Benefit Highlights Letter, Health Care Benefit Summary, or Summaries of Material Modifications, the Schedule of Benefits, Benefit Highlights Letter, or Summary of Material Modifications will govern. If there is any conflict or discrepancy between this SPD and the applicable Certificate or Evidence of Coverage or informal Enrollee communications, this SPD will govern. Silence in a Certificate or Evidence of Coverage, this SPD, or other governing document on a given topic is not a conflict or discrepancy.

The Plan Documents 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.

The Committee, on behalf of three separate employees' beneficiary associations (EBA), the Chrysler Retiree EBA, the Ford Retiree EBA, and the GM Retiree EBA, has created three separate retiree accounts. Each separate retiree account is a dedicated account to be used for the sole purpose of funding benefits to eligible Retirees and their Dependents in the respective EBA and defraying the expenses of that account. While the Trust assets are pooled for investment and administrative purposes, the assets attributable to any one separate retiree account may not offset liabilities or defray the expenses attributable to any other retiree account.

Contributions from Retirees and surviving Dependents may be required for participation in the Plan. Benefits are either self-funded and paid out of the Trust's assets or fully-insured and paid under an insurance policy between the Trust and a Carrier.

10. Administration

Except where provided under an HMO, MA plan and MA-PD plan, benefits under the Plans are administered by Carriers under an administrative services agreement with the Trust. HMOs and MA plans are administered by Carriers. The HMOs, MA plans and MA-PD 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 Enrollees 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 SPD 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 Amendment or Termination of the Trust

The Committee may terminate the Plan for the UAW Chrysler Retirees Medical Benefits Plan, UAW Ford Retirees Medical Benefits Plan, and/or UAW GM Retirees Medical Benefits Plan, as provided by the Settlement Agreements and the Trust Agreement. If the UAW Chrysler Retirees Medical Benefits Plan, UAW Ford Retirees Medical Benefits Plan, and/or UAW GM Retirees Medical Benefits Plan is terminated, retirees receiving benefits under that plan will no longer be eligible for coverage under the Trust.

15. 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.

16. 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.

17. 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 Enrollee. 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 an In-Network Provider, then the Plan or its Carrier may reduce or deny benefits, in the amount of the overpayment, for otherwise covered benefits for current and/or future claims with the In-Network Provider on behalf of any member or their Dependent(s). The Carrier may offset payments to the In-Network Provider that was overpaid.

18. State Law Preemption

With regard 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.

19. Uncashed Checks issued to Enrollees

An Enrollee 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.

20. Plan Interpretation

The Committee and its delegates will have the power to construe this SPD, the procedures and regulations of the Plan, and other the Plan documents, including ambiguous provisions. The Committee's interpretation will be binding on all involved parties hereto. The decisions of the Committee will be given judicial deference in any court proceeding regarding benefits of this Plan unless they are found to be arbitrary or capricious by a reviewing court.

E. 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 Enrollees 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 SPD/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 Primary Enrollee 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, Your Same-Sex Domestic Partner, 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 SPD and the 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.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Enrollees, 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 Enrollees and beneficiaries. No one, including the Trust, 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 SPD or the 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.

F. NON-RETALIATION

The Plan will take no action or discriminate 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 or governmental agency.

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 do not wish to be known as the source of the complaint, You or Your Dependent can call the compliance hotline ("ComplianceLine") at 1-888-250-6617. The Plan will investigate all inquiries.

G. 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. The Plan will not contribute to Your coverage in one of these plans either.

H. NON-DISCRIMINATION RIGHTS

The UAW Retiree Medical Benefits Trust ("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 Connect에 866-637-7555번으로 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 bezplatną pomoc i zadać pytania w tym i w wielu innych jezykach.

[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.

[اللغة العربية]
إذا أردت المساعدة أو الحصول على إجابات بهذه اللغة أو أية لغة أخرى، الرجاء الاتصال بمركز Retiree Health Care Connect على الرقم 7555-637-866. بإمكانك الحصول على المساعدة هناك وطرح اية أسئلة بدون أية رسوم، بهذه اللغة والعديد من اللغات الأخرى.

فارسی
اگر به کمک ای پاسخ هایی به این زبان ای زبان دیگری نیاز دارید، لطفاً با Retiree Health Care Connect به شماره 7555-637-866 تماس بگیرید. شما می توانید در آنجا به این زبان و بسیاری زبان های دیگر به طور رایگان کمک و راهنمایی دریافت کنید و سؤالاتی را بپرسید.

XII. 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 or Injuries

A bodily injury (such as a fracture, strain, sprain, abrasion, contusion, or other condition) caused unexpectedly or unintentionally 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 or drug, according to certain standards and considerations. In-Network Providers or Participating Retail Pharmacies have agreed to accept this Allowed Amount as payment in full even though their billed charge may be more.

Ambulatory Surgical Center/Facility or ASC

A facility, which may be connected to but is separate from a Hospital, which provides outpatient surgical services to individuals who do not require hospitalization.
Authorized Representative

A person who can act on an Enrollee's behalf to file a Claim or appeal under the Plan. The following individuals may be recognized as an Authorized Representative:

- Provider who is treating the Enrollee and who prescribes the treatment or service which is the subject of a Claim;
- Spouse;
- Dependent Child aged 18 or older;
- Parents or adult siblings;
- Court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator;
- Union benefit representative; or
- Other adult.

Auto Company

One of the following companies: Chrysler Group LLC (now known as Stellantis), 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 BlueCross BlueShield 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 Enrollees 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 Enrollee'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 for the UAW Retiree Medical Benefits Trust. 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, through direct debit (from Your bank), or billed directly to You. 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, regardless of the status of any applicable Deductibles or Out-of-Pocket Maximums. 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 doctor, are primarily for the purpose of meeting the personal needs of the Enrollee 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 Enrollee 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 Plan, the child must meet the eligibility requirements in Section I of this SPD.

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 CMS has granted the Trust in order to offer the Part D Plan.

Enrollee

Each Retiree or other Primary Enrollee and each of his or her eligible Dependents, if any, enrolled in coverage under the Plan.

Experimental and/or Investigational

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

- The service, supply, device or drug 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, supply, device or drug 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, supply, device, or drug as experimental or investigational or indicate that more research is required;
- The Food and Drug Administration (FDA) has not granted approval of the service, supply, device, or drug (if such FDA approval is required);
- The service, supply, device, or drug exceeds an FDA-approved limit; or
- The service, supply, device, or drug is available only through participation in clinical trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.
- If a service, supply, device, or drug is approved by the FDA, then the Carrier cannot classify the service, supply, device or drug as Experimental and/or Investigational.

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, the facility must have a contract with the Carrier for Your Plan.

Homebound

The Provider certifies that the Enrollee is confined to the home or has trouble leaving his or her home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury. The Enrollee does not have to be bedridden to be considered Homebound.

Home Health Care Agency

A centrally administered agency providing doctor-directed nursing and other paramedical services to Enrollees at home. To receive In-Network benefits for services received from a Home Health Care Agency, the agency 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, the program 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 doctors 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, the Hospital must have a contract with the Carrier for Your Plan.

In-Network Provider, Hospital, Facility, Supplier, Retail Clinic, or SNF

Provider, Hospital, facility, supplier, retail clinic, or SNF that participates in the Traditional Care Network (TCN), Enhanced Care PPO (ECP), or other networks providing Plan coverage, such as HMOs, MA-PDs, Humana Commercial, and MA PPOs and HMOs. In-Network Providers are also referred to as "Network Providers", "Participating Providers," or "Panel Providers." In-Network Hospitals are sometimes referred to as "Network

Hospitals." Each Carrier contracts with Providers, Hospitals, facilities, suppliers, retail clinics and SNFs to form its own network.

Medical Emergency

A Medical Emergency is a serious or permanent health threatening or disabling condition, including certain Accidental Injuries, that requires immediate medical attention and treatment. The condition must be of such a nature that an individual who possesses an average knowledge of health and medicine could reasonably expect that if treatment is not immediately received, significant damage to bodily function could occur, permanent damage to the Enrollee's health could occur, or the Enrollee's life may be at risk. Signs and symptoms verified by the Provider at the time of treatment, and not the final diagnosis, must confirm the existence of a Medical Emergency.

Medically Necessary (Medical Necessity)

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

- provided by or under the direction of a Provider 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 Enrollee or Provider's convenience;
- appropriate given the Enrollee's circumstances and condition;
- a "cost-efficient" supply or level of service that can be safely provided to the Enrollee;
- safe and effective for the illness or injury for which it is used; and
- not considered Experimental and/or Investigational

Medicare Providers

Providers that are approved by CMS 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 the Medicare program directly for services or items provided.

Non-Participating Pharmacy or Non-Participating Retail Pharmacy

A pharmacy that is not contracted with the PBM to participate in the PBM's network of pharmacies.

Non-Participating Provider, Hospital, facility, or SNF

A Provider, Hospital, facility, or SNF that does not have an arrangement with a Carrier for a particular fee or particular method of payment and is not contracted with CMS to participate in Medicare. If You receive non-Medical Emergency and/or non-Urgent Care services from a Non-Participating Provider, Hospital, facility or SNF, You may be responsible for the entity's billed charges, unless you have other coverage outside the Plan that covers these services.

Observation

Hospital outpatient services given to determine if an Enrollee needs to be admitted to the Hospital as an inpatient or can be discharged; an Enrollee may be in Observation for more than one day. Observation care must be ordered by a Provider or another health care professional authorized by state law and Hospital staff bylaws to admit individuals to the Hospital or order outpatient tests.

Off-Label Use

An unlabeled use of a drug or device is a use that is not included as an indication by its FDA approval.

Out-of-Network Provider, Hospital, Facility, Ambulatory Surgical Center/Facility, Retail Clinic, SNF, or DME Provider/Supplier

Provider, Hospital, facility, ambulatory surgical center or facility, Retail Clinic, Skilled Nursing Facility, or durable medical equipment provider or supplier that does not participate, but is willing to accept the Carrier's Allowed Amount, in the Traditional Care Network (TCN), Enhanced Care PPO (ECP), or other networks providing Plan coverage, such as Humana Commercial, HMOs, MA plans and MA-PD plans. When You use an Out-of-Network Provider, You generally are responsible for paying the applicable out-of-network Deductible and Coinsurance. Out-of-Network Providers also are referred to as "Non-Network Providers" 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 for Deductibles and Coinsurance, after which the Plan will pay for Your covered services at 100% except that You still must pay applicable Copayments. 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. Copayments generally do not count toward meeting Your Out-of-Pocket Maximum.

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, the facility must have a contract with the Carrier for Your Plan.

Partial Hospitalization Treatment Facility

Facility that provides a semi-residential level of care for Enrollees with mental health or substance use disorder disorders who require coordinated intensive, comprehensive, and multidisciplinary treatment in a structured setting, but less than full time hospitalization. The Enrollee 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, the facility must have a contract with the Carrier for Your Plan and be preapproved.

Participating Pharmacy or Participating Retail Pharmacy

A pharmacy that is contracted with the PBM to participate in the PBM's network of pharmacies.

Participating Provider, Hospital, Facility, or SNF

A Provider, Hospital, facility, or SNF that has an arrangement with a Carrier for a particular fee or particular method of payment and also may be contracted with CMS to participate in Medicare.

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.

Prior Authorization

A decision by the Carrier that must generally be made before You receive the item, service, or prescription drug, that such item, service, or prescription drug is medically necessary and will be a covered benefit under the plan. Prior Authorization may also be referred to as preapproval.

Primary Care Physician (PCP)

A doctor specializing in family medicine, internal medicine, obstetrics-gynecology, gerontology, or pediatrics who provides definitive care to the Enrollee at the point of first contact and takes continuing responsibility for providing the Enrollee'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 Treatment Facility

Facility that provides inpatient facility treatment for an Enrollee with mental health and/or substance use disorder(s). To receive in-network benefits for services received at a Residential Treatment Facility, the facility 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

A former Auto Company employee who is eligible for benefits under the Plan.

Retiree Health Care Connect

The service provider hired by the Trust to administer the Plan'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.

Same-Sex Domestic Partner

A person who is the same sex as the Retiree's current sex, is in a committed romantic relationship with the Retiree, shares a domestic life with the Retiree, and meets all eligibility tests for coverage under the Plan as a Same-Sex Domestic Partner.

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 or SNF

A facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a doctor 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 (SNF), the facility must have a contract with the Carrier for Your Plan.

Specialist

A doctor who provides health care services beyond the scope of primary care for a specific disease or part of the body. These doctors 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 under Internal Revenue Service ("IRS") rules. This includes an individual in a common-law marriage with a Retiree if the relationship is recognized under IRS rules.

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 needed for a sudden illness or injury that needs medical care right away but is not life threatening.

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 doctors, nurses, and other Providers 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(r)

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

Mailing Address for the Trust	Plan Administrator UAW Retiree Medical Benefits Trust P.O. Box 14309 Detroit, MI 48214

Call Centers

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

XIII. CARRIERS

The Carriers for all plans are listed below. If You are enrolled in a non-Medicare HMO, MA HMO, MA-PD HMO or PPO or Medicare Part D Prescription Drug plan, Your Certificate of Coverage or Evidence of Coverage, which is issued by the Carrier, provides additional information about Your benefits and the terms of Your plan. You can access Your Certificate of Coverage or Evidence of Coverage on the Trust's website at http://www.uawtrust.org/documents.

Traditional Care Network and Prescription Drug Coverage

Health Plan Carrier Name	Claim Inquiries	Appeals
Blue Cross Blue Shield of Michigan (TCN) 877-832-2829 http://www.bcbsm.com/uawtrust	UAW Auto Retiree Service Center P.O. Box 311088 Detroit, MI 48231	UAW Auto Retiree Appeals Unit – Mail Code 1620 Blue Cross Blue Shield of Michigan 600 Lafayette East Detroit, MI 48226
Blue Cross Blue Shield of Michigan (ECP) 866-507-2850 http://www.bcbsm.com/uawtrust	UAW Auto Retiree Service Center P.O. Box 311088 Detroit, MI 48231	UAW Auto Retiree Appeals Unit – Mail Code 1620 Blue Cross Blue Shield of Michigan 600 Lafayette East Detroit, MI 48226
New Directions (Mental Health/Substance Use Disorder Administrator) 877-228-3912 http://www.ndbh.com	UAW Auto Retiree Service Center P.O. Box 311088 Detroit, MI 48231	New Directions Behavioral Health ATTN: Appeals Coordinator PO Box 6729 Leawood, KS 66206
OptumRx (Pre-Medicare Prescription Drug Administrator) (PBM) 855-409-0219 https://retiree.uhc.com/uawtrustchoice	OptumRx Claims Department P.O. Box 29044 Hot Springs, AR 71903	OptumRx ATTN: Appeals Coordinator PO Box 2975 Mission, KS 66201

Health Plan Carrier Name	Claim Inquiries	Appeals
OptumRx Part D Plan (Medicare Prescription Drug Administrator) (PBM) 855-409-0219 https://retiree.uhc.com/uawtrustchoice	OptumRx Claims Department P.O. Box 650287 Dallas, TX 75265-0287	OptumRx ATTN: Part D Appeals and Grievance Department P.O. Box 6106 MS CA124-0197 Cypress, CA 90630-0016

Dental, Vision, and Hearing Coverage

Health Plan Carrier Name	Claim Inquiries	Appeals
Delta Dental (Dental Administrator) 800-524-0149 http://www.deltadentalmi.com	General Claims Inquiries: Delta Dental P.O. Box 9089 Farmington Hills, MI 48333-9089 Claims Submissions: Delta Dental P.O. Box 9085, Farmington Hills, Michigan 48333-9085	Dental Director Delta Dental P.O. Box 30416 Lansing, MI 48909-7916
Davis Vision (GM, Chrysler, and Ford Vision Administrator) 888-234-5164 http://www.davisvision.com	Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110	Davis Vision Quality Assurance P.O. Box 791 Latham, NY 12110-0791
TruHearing (Hearing Benefit Administrator) 844-394-5420 https://www.truhearing.com/uawtrust	Claims Inquiries 844-394-5420 TruHearing Attn: Grievance Team 12936 Frontrunner Blvd Ste 100 Draper UT 84020	Appeals 844-394-5420 TruHearing Attn: Grievance Team 12936 Frontrunner Blvd Ste 100 Draper UT 84020

Medicare Advantage Prescription Drug Coverage

Health Plan Carrier Name	Claim Inquiries	Appeals
Blue Cross Blue Shield of Michigan (MAPD) 888-322-5616 http://www.bcbsm.com/uawtrust	For Medical: Blue Cross Blue Shield of Michigan Imaging and Support Services P.O. Box 32593 Detroit, MI 48232-059 For Prescriptions: Optum RX Claims Department PO Box 650687 Dallas, TX 75265-0287	Blue Cross Blue Shield of Michigan Grievances and Appeals Department P.O. Box 2627 Detroit, MI 48231-2627
UnitedHealthcare (MAPD) 1-844-320-5021 retiree.uhc.com/UAWTrust	Claims inquiries: 1-844-320-5021 UnitedHealthcare Customer Service Department P.O. Box 30770, Salt Lake City, UT 84130-0770 For Prescriptions: TFN for claims inquiries: 1-844-320-5021 UnitedHealthcare Customer Service Department P.O. Box 30770, Salt Lake City, UT 84130-0770	Medical and Prescription Drug appeals: 1-844-320-5021 Medical: UnitedHealthcare Appeals and Grievances Department P.O. Box 6106, MS CA124-0157, Cypress, CA 90630-0016 Fax for standard appeals for medical care only: 1-888-517-7113 Fax for fast/expedited appeals for medical care only: 1-866-373-1081 Prescription Drug: UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA124-0197, Cypress, CA 90630-0016 Fax for standard Part D prescription drug appeals: 1-866-308-6294 Fax for fast/expedited Part D prescription drug appeals: 1-866-308-6296

Health Maintenance Organizations

Health Plan Carrier Name	Claim Inquiries	Appeals
Blue Care Network Plan (HMO) 800-222-5992 TTY users call 711 http://www.bcbsm.com/uawtrust	BCN Advantage Blue Care Network 2311 Green Road- Mail Code A103 Ann Arbor, MI 48105 Phone: 1-800-222-5992 TTY users call 711 Fax: 1-866-364-0080	BCN Advantage Appeals and Grievance Unit Mail Code C248 20500 Civic Center Dr. Southfield, MI 48076 Phone: 1-800-222-5992 TTY users call 711 Fax: 1-866-522-7345
Blue Care Network Plan (HMO) 800-222-5992 TTY users call 711 http://www.bcbsm.com/uawtrust	HMO: BCN Claims P.O. Box 68710 Grand Rapids, MI 49516-8710 BCNA: BCN Advantage Blue Care Network P.O. Box 68753 Grand Rapids, MI 49516-8753	BCN: BCN Grievance and Appeals Unit P.O. Box 284 Southfield, MI 48037-0284 FAX: 866-522-7345 BCN Advantage Appeals & Grievance Unit Mail Code H305 Blue Care Network P.O. Box 284 Southfield, MI 48037-9887 FAX: 866-522-7345
Green Shield (Canadian Health Plan) 888-711-1119 http://www.greenshield.ca	Self-serve using Your Plan Member Online Services Account Send an inquiry via www.greenshield.ca/en-ca/get-in-touch P.O. Box 1606 Windsor, ON N9A 6W1	P.O. Box 1606 Windsor, ON N9A 6W1 Attention: Supervisor "insert claim type" Department Customer.service@greenshield.ca
Health Alliance Plan (HMO) 800-422-4641 (Commercial) 800-801-1770 (Medicare Advantage) http://www.hap.org	2850 W. Grand Blvd. Detroit, MI 48202 Attn: Claims	2850 W. Grand Blvd. Detroit, MI 48202 Attn: Manager of Grievance Department 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

Health Plan Carrier Name	Claim Inquiries	Appeals
Humana (Pre-Medicare and Medicare) 800-758-5002 http://www.humana.com	Humana Claims P.O. Box 14601 Lexington, KY 40512-4601	Grievance and Appeals P.O. Box 14546 Lexington, KY 40512-4546
Kaiser Permanente Northern California (HMO) 800-464-4000 http://www.kp.org	Kaiser Foundation Health Plan Claims and Referrals Member Services P.O. Box 12923 Oakland, CA 94604-2923 Phone: 800-390-3510	Kaiser Foundation Health Plan Claims Appeal Department PO Box 23280 Oakland, CA 94623-0280 Fax: 1-510-625-6124 Member Services: 800-464-4000
Kaiser Permanente Southern California (HMO) 800-464-4000 http://www.kp.org	Kaiser Foundation Health Plan Claims and Referrals Member Services P.O. Box 7004 Downey, CA 90242-7004 Phone: 800-390-3510	Kaiser Foundation Health Plan Special Services Department PO Box 7136 Pasadena, CA 91109-7136 Fax: 1-877-516-0906 Member Services: 800-464-4000
Kaiser Permanente Northwest (HMO) 800-813-2000 http://www.kp.org	Kaiser Foundation Health Plan of the Northwest Claims Administration P.O. Box 370050 Denver, CO 80237- 9998 Phone: 866-441-1221	Kaiser Foundation Health Plan of the Northwest Member Relations Department 500 NE Multnomah St. Suite 100 Portland, OR 97232-2099
Kaiser Permanente Georgia (HMO) 404-261-2590 or 888-865-5813 http://www.kp.org	Kaiser Permanente Claims Administration P.O. Box 370010 Denver, CO 80237-9998 Phone: 404-261-2825	Kaiser Permanente Appeals Department Nine Piedmont Center 3495 Piedmont Road, N.E. Atlanta, GA 30305-1736 Fax: 1-404-364-4743
Kaiser Permanente Colorado (HMO) 800-382-4661 or 303-338-3800 http: //www.kp.org	Kaiser Permanente Claims Department P.O. Box 373150 Denver, CO 80237-3150	Kaiser Permanente Appeals Program P.O. Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042

Health Plan Carrier Name	Claim Inquiries	Appeals
Kaiser Permanente Mid-Atlantic (HMO) 301-468-6000 [DC Area] 800-777-7902 http://www.kp.org	Kaiser Permanente Claims Unit P.O. Box 371860 Denver, CO 80237-9998 Phone: 800-777-7902	Kaiser Permanente of Georgia Member Relations Dept. 3495 Piedmont Road NE Building 9 Atlanta, GA 30305 Fax: 1-404-364-4743 Phone: 800-777-7902

UAW RETIREE
Medical Benefits Trust

Retiree Health Care Connect 866-637-7555
www.uawtrust.org