HEALTH CARE BENEFITS SUMMARY
FOR
UAW-FORD RETIREES

2017

THE FOLLOWING INFORMATION IS AN ADDENDUM TO THE SUMMARY PLAN DESCRIPTION PUBLISHED IN JANUARY 2015.

Unless otherwise noted, the information contained in this package is effective January 1, 2017.

Dear Trust Member,

The goal of the UAW Retiree Medical Benefits Trust (the “Trust”) is to provide comprehensive medical benefits to our members. Each year, we focus on managing our health plan partners and aim to provide you with the best value in terms of quality, cost, and overall customer experience.

The Trust’s objective is to provide you with tools to make informed decisions about your health and health care plan options. The information contained within this package should assist you in making these decisions, as well as serve you in the future to review your benefits, along with important phone numbers and websites.

As always, we want to remind you and your family to establish a relationship with a primary care physician and visit him or her for your wellness check-ups and annual physical. Don’t forget to discuss with your physician the need for any age-related tests such as mammograms, colonoscopies, and cancer screenings. Also make sure that you are up-to-date on your immunizations and get your annual flu shot.

This document, along with plenty of other useful information, is available at www.uawtrust.org. We continue to update our website in order to make it a valuable resource for you. You can find videos detailing the history, structure, and funding of the Trust, as well an overview of each year’s benefits in video form as they are released.

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

We wish all of our members the very best and many healthy years ahead.

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

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If you are enrolled in an HMO or Medicare Advantage plan, the Carrier for the Plan will provide you with a booklet, such as an Evidence of Coverage or Certificate of Coverage, that describes the detailed terms of your coverage and the rules that govern your particular Plan. If you have questions about any of this information, contact Retiree Health Care Connect at 866-637-7555 or the Carrier of your Plan.

PENSION DEDUCTIONS

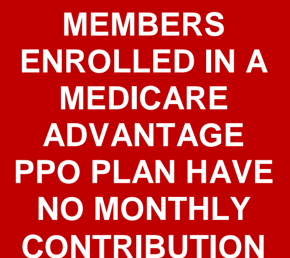
Trust members are required to make monthly contributions for health care benefits.

Your contributions will be deducted monthly from your pension check. Your first pension check may have deductions retroactive to your Trust effective date. If you do not have sufficient funds in your pension to cover your monthly contributions, or are not receiving a pension benefit, you may contact Retiree Health Care Connect (RHCC) at 866-637-7555 to enroll in the direct debit option.

MONTHLY CONTRIBUTION FOR ALL PLANS

Single*	$17
Family*	$34

*Protected Population: Single or Family – $0



AVAILABLE HEALTH PLANS

Your health plans and/or benefits may change as a new retiree or Surviving Spouse. Depending on your geographic location, you may have several plan options available to you, including Traditional Care Network (TCN), Health Maintenance Organization (HMO) and for Medicare participants, Medicare Advantage (MA) Plans.

Medicare-enrolled members are encouraged to consider MA plans available in their area. There is no monthly contribution requirement for members who enroll in an MA PPO plan.

COST SHARING

The assets in the Trust must be used to provide health care benefits for all current and future eligible members. The level of covered benefits is set every year after balancing the Trust's available funds with members' contributions. You will find the current cost sharing items on the next several pages.

TRADITIONAL CARE NETWORK (TCN) COST SHARE

The TCN plan is the base plan option available to all Trust members. This plan utilizes a nationwide network of doctors and facilities, and allows services to be performed both in-network and out-of-network. In order to receive the highest level of benefits with the lowest out-of-pocket cost, you should check to see whether your providers participate in the network. Deductible, coinsurance and out-of-pocket maximum amounts are always higher when you use an out-of-network provider.

Who is eligible? All Trust members—both **Non-Medicare and Medicare**.

	In-Network	Out-of-Network
Deductible[1] (The amount you pay annually before the Plan begins to pay a portion of the costs)	**$400 Single $675 Family**	**$1,000 Single $1,700 Family**
Coinsurance[1] (The amount you pay after your deductible is met)	**10%**	**30%**
Out-of-Pocket Max[1] (The TOTAL amount you pay annually before the Plan pays 100% of covered costs)	**$800 Single $1,475 Family**	**$3,000 Single $5,550 Family**

	Non-Medicare	Medicare
Primary Care Physician (PCP) and Specialist Office Visit Copays*	**$25 per visit for six (6) routine PCP visits Specialist office visits not covered**	**Covered by Medicare at 80%, after Part B deductible is met; Member pays remaining 20%**
Urgent Care Copay* (including Retail Clinics)	**$50**	
Emergency Room Copay (waived if admitted)	**$125**	

Copay amounts are separate from the deductible and generally do not apply towards meeting your deductible or out-of-pocket maximum.

[1] Cost share does not apply to Protected Population.

* Reflects in-network costs. Refer to plan materials for out-of-network costs.

MEDICARE ADVANTAGE (MA) PPO COST SHARE

Medicare Advantage plans are approved by Medicare and administered by private insurance companies. They provide all of your Original Medicare Part A (hospital) and Part B (medical) benefits, and additional benefits. MA PPO plans also utilize a nationwide network of doctors and facilities and allow services to be performed both in-network and out-of-network. In order to receive the highest level of benefits with the lowest out-of-pocket cost, you should check to see whether your providers participate in the network. Deductibles, coinsurance and out-of-pocket maximum amounts are always higher when you use an out-of-network provider.

Who is eligible? Trust members who are enrolled in both Medicare Parts A and B and living in one of the states where there are MA PPO plan offerings. To stay eligible for these plans, you must continue to pay your monthly Medicare Part B premium.

	In-Network	Out-of-Network
Deductible (The amount you pay annually before the Plan begins to pay a portion of the costs)	$245 per Person	$490 per Person
Coinsurance (The amount you pay after your deductible is met)	10%	30%
Out-of-Pocket Max (The TOTAL amount you pay annually before the Plan covers 100% of covered costs)	$630 per Person	$1,395 per Person

Primary Care Physician (PCP) and Specialist Office Visit Copays*	$20 per PCP visit $25 per Specialist visit
Urgent Care Copay* (including Retail Clinics)	$25
Emergency Room Copay (waived if admitted)	$50

Copay amounts are separate from the deductible and generally do not apply towards meeting your deductible or primary out-of-pocket maximum.

* Reflects in-network costs. Refer to plan materials for out-of-network costs.

HEALTH MAINTENANCE ORGANIZATION (HMO) COST SHARE

HMO plans are regionally based plan offerings that are only available in select areas. These plans utilize a regional network of doctors and facilities and do not typically allow any non-emergency services to be performed out-of-network. In order to ensure that services are covered, you should check to see whether your providers participate in the network.

Deductible*	**$400 Single $675 Family**
Primary Care Physician (PCP) and Specialist Office Visit Copays*	**$25 per PCP visit $35 per Specialist visit**

	Non-Medicare	Medicare
Urgent Care Copay* (including Retail Clinics)	**$50**	**$25**
Emergency Room Copay* (waived if admitted)	**$125**	**$50**

* Cost share differs for Protected members. See HMO plan detail information for actual costs.

PRESCRIPTION DRUG COPAYS FOR ALL PLANS

Most Trust medical plans have prescription drug coverage administered by Express Scripts (excluding select HMO plans). No matter the medical plan option you choose, below are the copay amounts for your prescription drug benefit:

	Retail (One-Month Supply)	Mail-Order (90-Day Supply)
Tier 1 Generic	**$14**	**$24**
Tier 2 Preferred Brand	**$45**	**$85**
Tier 3 Non-Preferred Brand	**$115**	**$230**

MEDICARE PART B PREMIUM BENEFIT

A Medicare Part B Premium Benefit is provided to help you pay for Medicare Part B coverage. You will receive this benefit if you are a Retiree or Surviving Spouse eligible to receive a benefit under the UAW-Ford Retirement Plan (other than a benefit payable as a result of a deferred vested benefit or a pre-retirement survivor benefit). The benefit will be paid automatically once the Trust is notified by Medicare of your enrollment.

Retirees and Surviving Spouses eligible for Medicare Part B must enroll and maintain continued enrollment in Medicare Part B to be eligible to receive this Benefit. Proof of Part B enrollment is required. Retirees under age 65 who are disabled or have End State Renal Disease are also eligible to receive the Benefit, provided they are enrolled in Medicare Part B. If you are eligible, the Medicare Part B Premium Benefit will be included in your pension check.

Your spouse is not eligible for the Benefit. However, your Surviving Spouse will be eligible when you pass away, if he or she receives a survivor pension benefit (other than a surviving spouse benefit payable as a result of a deferred vested benefit or a pre-retirement survivor benefit) and is enrolled in Medicare Part B when eligible.

OUTPATIENT PHYSICAL THERAPY

TheraMatrix Physical Therapy Network administers outpatient physical therapy benefits for members enrolled in the Blue Cross Blue Shield Traditional Care Network (TCN) health plan. Members have coverage for up to 60 outpatient physical, speech and occupational therapy visits per condition per year. Before you receive physical therapy services, you must obtain pre-approval from TheraMatrix. You will only receive pre-approval if your condition is expected to improve in a reasonable and generally predictable period of time, or if you have improvement noted on a periodic basis. Physical therapy services must be performed by an in-network provider. This network may be more restrictive than the network for other kinds of therapy and may not include all covered locations under Medicare. Contact TheraMatrix at 888-638-8786 to find an in-network participating provider. You may also access their website at www.theramatrix.com.

Members who are not enrolled in the Traditional Care Network plan should contact their medical plan before obtaining outpatient physical therapy services to review what pre-approval and network requirements may exist.

VISION COVERAGE

HOW VISION COVERAGE WORKS

Vision coverage provides assistance toward the cost of routine eye exams, lenses, and frames through a national network of participating ophthalmologists, optometrists, and optical facilities. Services covered under vision provisions include, but are not necessarily limited to, the items below:

- One vision examination (by an optometrist or an ophthalmologist) once every 12 months plus one referral (when medically necessary) to an ophthalmologist for re-examination within 60 days from the date of initial examination. (Members residing within 25 miles of a network provider must obtain a referral from a network provider.)
  - Members who are an insulin-dependent diabetic may obtain two vision examinations each calendar year. If you have diabetes, it is important to have the Dilated Eye Exam every year, even if you're not having problems with your vision.
- One pair of lenses and frames or contact lenses once every 24 months.
  - Contact lenses may be obtained instead of regular lenses and frames, not in addition to.
- When eligible for lenses, and until the member's thirteenth birthday, coverage will be provided for scratch-guard coating on plastic lenses when received from a network provider. Scratch-guard coating will be covered under the program not more than once every two calendar years.
- Warranty on lenses and/or frames received from a network provider.

  Most lenses or frames received from a network provider are under warranty for one year. The warranty begins on the date you receive your lenses and/or frames. Contact SVS Vision for more information.

* HAP HMO members have vision coverage through HAP HMO. Refer to plan materials for coverage details.

VISION COVERAGE AT-A-GLANCE

Services	Coverage when service obtained from:		
	Network Provider	Non-Network Provider	Non-Network Provider (but member lives more than 25 miles from a network provider)
Vision Testing Exam	Full Coverage	Not Covered	$45 Allowance
Reexamination by an Ophthalmologist	$45 Allowance	Not Covered	$45 Allowance
Regular Lenses (glass or plastic) - Single Vision - Bifocal - Trifocal - Special (lenticular, aspheric, etc.)	Full Coverage	$13 Allowance	$59 Allowance $79 Allowance $99 Allowance $99 Allowance
Lens Options - Scratch-resistant coating for those age 13 & under	Full Coverage	Not Covered	Not Covered
Standard Frames	Full Coverage	$13 Allowance	$49 Allowance
Designer Frames	$40 Allowance	$13 Allowance	$49 Allowance
Contact Lenses (instead of eyeglasses) - Not medically necessary hard lenses instead of soft contact lenses	$75 Allowance	$37 Allowance	$89 Allowance
Contact Lenses Evaluation, fitting and follow-up care	$40 Allowance	Included Above	Included Above
Contact Lenses deemed medically necessary to achieve 20/70 in better eye or to correct keratoconus, irregular astigmatism, or irregular corneal curvature as diagnosed by an M.D. or O.D. (includes professional fees and contact lenses)	Up to $350	$52.50 Allowance	$200 Allowance

VISION COVERAGE EXCLUSIONS

Vision services excluded from coverage include but are not limited to:

- Any lenses that do not require a prescription
- Medical or surgical treatment of the eye
- Drugs or any other medication not administered for the purpose of a vision testing examination
- Visual training, orthoptics, visual therapy for learning disorders, low vision aids, aniseikonic lenses, aphakic lenses (if for conditions of surgical aphakia and tonography)
- Vision testing examinations, lenses, or frames furnished for any condition, disease, aliment or injury arising out of and in the course of employment
- Vision testing examinations performed and lenses and frames ordered before you become eligible for coverage or after the termination of your coverage
- Lenses or frames which are not necessary according to accepted standards of ophthalmic practice, or which are not ordered or prescribed by the attending physician or optometrist
- Changes for vision testing examinations, lenses or frames to the extent for which benefits are payable under any health care programs supported in whole or in part by funds of the Federal government or any state of political subdivision thereof
- Charges for vision testing examinations, lenses or frames to the extent for which benefits are payable under any other group policy or pre-payment arrangement
- Lenses or frames ordered while coverage is in effect but delivered more than sixty (60) days after coverage is terminated
- Charges which exceed the stated reimbursement levels or which otherwise exceed plan benefits

VISION NETWORK PROVIDERS

The vision network is made up of vision providers who have agreed to accept reimbursement based on a regional fee schedule, to meet certain contractual standards of quality, and to provide a selection of frames available to you at no cost.

Going to a participating vision network provider will reduce your out-of-pocket expenses. In addition, participating providers can check on your eligibility, file your claim, and be authorized by you to receive the reimbursement for covered services directly from the Vision Benefits Manager. Information about participating providers in your area is available by calling SVS Vision at 800-225-3095.

Generally, if you choose to receive covered vision services from a non-participating vision provider you will have to pay the provider and file your own claim with SVS Vision. SVS Vision will reimburse you directly based on a fee schedule.

How do I submit a claim for services received from a Non-Network provider?
If you or your eligible dependent receives services from a non-network provider, you must submit a claim form. Claim forms are available upon request from SVS Vision or by visiting the following web site: www.svsvision.com. Submit completed claim forms, along with your itemized receipt, to SVS Vision Managed Care, Inc. P.O. Box 464, Mt. Clemens, MI 48046-0464. You will be reimbursed up to the amounts described. If you or your eligible dependent receives vision care services from a Network provider, no claim forms are required.

If you live more than 25 miles from a participating provider and choose to receive covered services from a non-participating provider, then your reimbursement will be based on the Allowed Amount as determined by SVS Vision.

HEARING AID COVERAGE

Coverage is offered by a particular administrator according to the chart below:

Medical Plan	Plan Option	Administrator
Blue Cross Blue Shield of Michigan	Non-Medicare & Medicare TCN Members	AudioNet America
Humana	Non-Medicare PPO Members	AudioNet America
	Non-Medicare HMO and Medicare PPO Members	Humana—See Plan Materials for Hearing Coverage Description rather than coverage details stated below
HMO Plans	Non-Medicare & Medicare HMO Members	HMO Plan Carrier—See Plan Materials for Hearing Coverage Description rather than coverage details stated below
MA PPO Plans	All Members in Plan	MA Plan Carrier—See Plan Materials for Hearing Coverage Description rather than coverage details stated below

Services must be performed by an in-network provider with the appropriate benefit administrator to receive full coverage of your hearing aids. Call AudioNet America, administered by SVS, Inc. at 877-500-7370 for assistance with finding an in-network provider.

EXPLANATION OF TERMS

"**Participating Provider**" means a physician, audiologist or dealer that participates in the AudioNet America Hearing Aid Program administered by SVS, Inc.

A "**dealer**" means any participating person or organization that sells hearing aids prescribed by a physician or audiologist to improve hearing acuity in compliance with the laws or regulations governing such sales, if any, of the state in which the hearing aids are sold.

"**Physician**" means an Otologist, Otolaryngologist or Otorhinolaryngologist who is board certified or eligible for certification in his/her specialty in compliance with standards established by the respective professional sanctioning body, who is a licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of his/her license, performs a medical examination of the ear and determines whether the patient has a loss of hearing acuity and whether the loss can be compensated for by a hearing aid.

An "**audiologist**" means a person who (1) possesses a master's or doctorate degree in Audiology or speech pathology from an accredited university, (2) possesses a Certificate of Clinical Competence in Audiology from the American Speech-Language-Hearing Association and (3) is qualified in the state in which the service is provided to conduct an audiometric examination and hearing aid evaluation test for the purposes of measuring hearing acuity and determining and prescribing the type of hearing aid that would best improve the covered person's loss of hearing acuity. Where a physician performs the foregoing services he/she shall be deemed an audiologist for the purposes of this Program.

AUDIONET HEARING COVERAGE AT-A-GLANCE

SERVICE	PARTICIPATING PROVIDER	HOW OFTEN	WHAT DOES THIS MEAN TO YOU
Audiometric Examination	Covered In Full	Once every 36 months	Audiometric examination tests must be performed by a physician or audiologist.
Hearing Aid Evaluation Test (including conformity evaluation)	Covered In Full	Once every 36 months per ear	Hearing aid evaluation tests must be performed by a physician or audiologist. Conformity evaluation means, after a hearing aid is prescribed and fitted, one visit to the prescribing physician or audiologist by the covered person subsequent to obtaining the hearing aid for an evaluation of its performance and a determination of its conformity to the prescription.
Digital Hearing Aids (including acquisition costs and dispensing fees)	Two (2) mid-level standard digital hearing aids Covered In Full	Once every 36 months per ear	Hearing aid means an electronic devise worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing and includes the following, if necessary: 1) a single hearing aid unit or binaural hearing aids if the person qualifies; 2) ear mold, necessary cords, tubing and connectors; 3) standard package of batteries; 4) earphone (often referred to as a receiver) or oscillator; and 5) two-year repair warranty and one-year loss and damage warranty.
Replacement Ear Molds (for children up to age 7)	Covered In Full	No more than 4 replacement ear molds annually for children up to age 3. Not more than 2 replacement ear molds annually for children ages 3 – 7	Children up to age 3 will be eligible for no more than 4 replacement ear molds annually. Children ages 3 – 7 are eligible for no more than 2 replacement ear molds annually.
Ear Molds (enrollees over age 7)	First is Covered In Full. Additional molds are charged to enrollee	First is included with initial hearing aid	Enrollees over the age of 7 will be eligible for no more than the initial ear mold. Any additional molds are not covered by the plan.
Accessories	Not covered		Accessories such as additional batteries, amplifiers, wireless remotes, audio streamers, cleaning kits, etc. are not covered under the plan.
Maintenance / Fitting / Follow-Up Visits	Covered In Full within 6 months, $20 copay thereafter		For first 6 months, office visits with AudioNet physician or audiologist are paid in full. Members will be charged $20 copay after 6 months expires.

HEARING COVERAGE EXCLUSIONS

Hearing aid services not covered under the Trust include:

- Services and equipment obtained from Non-Network providers exceeding the discounted (reimbursement) amount for hearing aid services that would have been paid if service(s) were obtained in-network
- Medical or surgical treatment
- Drugs or other medication
- Audiometric examinations, hearing aid evaluation tests and hearing aids provided under any applicable Workers' Compensation Law
- Audiometric examinations and hearing aid evaluation tests performed and hearing aids ordered (1) before the covered person becomes eligible for coverage; or (2) after termination of coverage
- Hearing aids ordered while covered but delivered more than sixty days after termination of coverage
- Charges for audiometric examinations, hearing aid evaluation tests and hearing aids for which no charge is made to the covered person or for which no charge would be made in the absence of Hearing Aid Program expense benefits coverage
- Charges for audiometric examinations, hearing aid evaluation tests and hearing aids which are not necessary, according to professionally accepted standards of practice, and, in the case of an initial hearing aid or any hearing aid for a person under age 18, charges for hearing aid evaluation tests and hearing aids which are not recommended or approved by the physician
- Charges for audiometric examinations, hearing aid evaluation tests and hearing aids that do not meet professionally accepted standards of practice, including charges for any such services or supplies that are experimental in nature
- Charges for audiometric examinations, hearing aid evaluation tests and hearing aids received as a result of ear disease, defect or injury due to an act of war declared or undeclared
- Charges for audiometric examinations, hearing aid evaluation tests and hearing aids provided by any governmental agency that are obtained by the covered person without cost by compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body
- Services or supplies provided in a United States government hospital not operated for the general Public
- Charges for any audiometric examinations, hearing aid evaluation tests and hearing aids to the extent benefits therefore are payable under any health care program supported in whole or in part by funds of the federal government or any state of political subdivision thereof
- Replacement of hearing aids that are lost or broken unless at the time of such replacement the covered person is otherwise eligible under the frequency limitations set forth herein
- Charges for the completion of any insurance forms
- Replacement parts for and repairs of hearing aids, except replacement ear molds for children up to age seven
- Charges incurred by person enrolled in alternative plans
- Eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one hearing aid
- Charges for failure to keep a scheduled visit with a provider
- Charges for binaural or "spare" hearing aids, unless the covered person qualifies for a binaural hearing aid as referred to under the Schedule of Benefits
- Hearing aids that do not meet Food and Drug Administration (FDA) and Federal Trade Commission (FTC) requirements

DENTAL COVERAGE

HOW DENTAL COVERAGE WORKS

The Trust provides dental coverage to you and your eligible dependents. Delta Dental of Michigan administers this coverage. The specific provisions of the dental coverage, the range of covered services, eligibility rules and so forth may change from time to time. If you have questions as to whether or not a particular dental service or expense is covered, you should contact Delta Dental at 800-524-0149 or have your dentist submit a treatment plan for expenses $200 or more before receiving treatment, to ensure that you will not incur unexpected expenses for dental treatment.

Under the Delta Dental PPO Point-of-Service Plan (PPO POS), dental services for you and your eligible dependents are paid at the benefit level outlined below under the Dental Coverage At-A-Glance chart. You do not have to satisfy a dental deductible before the plan covers the services. Dental benefits are paid up to a maximum of $1,700 per person per calendar year.

Orthodontia services are covered for all plan participants who are under age 19. Most orthodontic services are covered at 50%, subject to a lifetime maximum of $2,000.

Payments for covered dental services related to the repair of accidental injury to sound natural teeth due to a sudden unexpected impact from outside the mouth are not counted against the annual benefit limit or the lifetime orthodontic limit. Instead, the regular copayments under medical coverage provided by the plan will be required for all such services. Similarly, dental services provided in a hospital are not covered as dental benefits, but may be covered as medical expenses if they qualify for such coverage.

DENTAL COVERED CHARGES

Your Delta Dental plan benefits cover a dentist’s charges that you are required to pay for necessary dental services and supplies, up to the Allowed Amount for such services. If you have a dental problem that can be treated in more than one way, the procedure that provides a cost-effective, professionally satisfactory result is covered.

PRE-TREATMENT ESTIMATE OF DENTAL BENEFITS

If treatment of planned dental work is expected to cost $200 or more, your dentist should file a pre-treatment estimate of benefits or “treatment plan” with Delta Dental **before treatment begins**. Delta Dental then can authorize payments before your dentist begins work, and you will know in advance exactly how much your dental coverage will pay. Your dentist may obtain a form from Delta Dental’s website at www.deltadentalmi.com.

Delta Dental will determine what portion of the total expenses will be paid by your dental coverage, taking into account alternate procedures, services or courses of treatment, based on accepted standards of dental practice. Delta Dental will then notify you and your dentist of the determination.

DENTAL COVERAGE AT-A-GLANCE

Services	PPO Dentist	Premier Dentist	Non-Participating Dentist
	% the Plan Pays		
DIAGNOSTIC & PREVENTIVE			
Preventive and Diagnostic Services (Exams, cleanings, fluoride and space maintainers)	100%	100%	100%
Emergency Palliative Treatment (To temporarily relieve pain)	100%	100%	100%
Brush Biopsy (To detect oral cancer)	100%	100%	100%
Periodontal Maintenance (Cleanings following periodontal therapy)	100%	100%	100%
BASIC SERVICES			
Radiographs (X-rays)	100%	90%	90%
Minor Restorative Services (Fillings and crown repair)	100%	90%	90%
Endodontic Services (Root canals)	100%	90%	90%
Periodontic Services (To treat gum disease)	100%	90%	90%
Extractions (Removal of teeth)	100%	90%	90%
Relines and Repairs (To bridges, implants and dentures)	100%	90%	90%
Major Restorative Services (Crowns)	90%	90%	90%
Other Oral Surgery (Dental surgery besides extraction)	90%	90%	90%
MAJOR SERVICES			
Adjustments to Dentures (Adjustments to complete or partial dentures)	70%	50%	50%
Prosthodontic Services (bridges and dentures)	70%	50%	50%
ORTHODONTIC SERVICES			
Orthodontic Services (Braces - Treatment must begin prior to age 19 and coverage will continue to the end of treatment or until the maximum has been reached)	60%	50%	50%

DENTAL EXPENSE LIMITATIONS

Under the Delta Dental Plan, certain dental services have limitations. You will be notified of these limitations when your treatment plan is considered or at the time you receive services. If you have any question about dental limitations, please contact Delta Dental at 800-524-0149.

Benefits for the following services or supplies are limited, unless otherwise specified. All charges for services or supplies that exceed these limitations will be your responsibility. **Please note, this list does not include all limitations. Contact Delta Dental or refer to the Plan Document for a complete list.**

- Oral examinations and evaluations are only payable twice per calendar year, regardless of the dentist’s specialty.
- Any combination of teeth cleanings (prophylaxes, full mouth debridement and periodontal maintenance procedures) are payable twice per calendar year. A third prophylaxes is payable in the same calendar year for individuals with a documented history of periodontal disease and a fourth prophylaxes is payable for two consecutive calendar years following periodontal surgery. Full mouth debridement is payable only once in a lifetime.
- Bitewing X-rays are payable once per calendar year. Panoramic or full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Crowns, onlays, metallic inlays and substructures are payable once per tooth in any three-year period. Veneers are payable on incisors, cuspids and first bicuspids once per tooth in any three-year period for children ages 8 through 19.
- Implants and related services are not covered services.
- Bridgework, substructures, full and partial dentures are limited to once in a five-year period.

DENTAL EXPENSE EXCLUSIONS

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the services will be your responsibility. **Please note, this list does not include all exclusions. Contact Delta Dental or refer to the Plan Document for a complete list of exclusions.**

- Services for injuries or conditions payable under Worker’s Compensation or Employer’s Liability laws. Services received from any government agency, political subdivision, community agency, foundation or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX of the Social Security Act; that is Medicaid.
- Services or supplies, as determined by Delta Dental, for correction of congenital or development malformations.
- Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
- Services started or appliances started before a person became eligible under this Plan. This exclusion does not apply to orthodontic treatment in progress (if a covered service.)
- Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions and relative analgesia.
- General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
- Charges for hospitalization, laboratory tests and histopathological examinations.
- Charges for failure to keep a scheduled visit with the dentist.

HEALTH PROGRAMS

The Trust recognizes the important role health education programs play in managing your overall health and well-being. We are pleased to offer the following programs to members enrolled in Trust Coverage. Members may contact their health plan for details about each of these programs and specific information about program enrollment.

PROGRAM	PROGRAM DESCRIPTION	BENEFITS TO YOU
Smoking Cessation	**A comprehensive smoking cessation program that coordinates and utilizes counseling and prescription drug therapy**	**While the Trust currently covers certain formulary-approved prescription drugs to help members stop smoking, the most effective programs also include telephonic or web-based behavioral counseling (Must be enrolled in smoking cessation program for prescriptions)**
Cardiac Rehabilitation	**Covers cardiac rehab as part of a therapy benefit for members who have had a qualifying cardiac event**	**Cardiac rehab helps with recovery and establishes sustainable behavior modifications**
Diabetes Education	**Covers comprehensive, American Diabetes Association-approved education classes for newly-diagnosed or uncontrolled diabetics**	**Classes taught by certified diabetes educators that cover topics such as proper nutrition and foot care. Classes are designed to help members self-manage their condition in order to prevent future complications**

ADDITIONAL PLAN PROVISIONS

ADVANCE CARE PLANNING OFFICE VISIT

The Trust covers Advance Care Planning under all health plans. Advance Care Planning is a discussion that physicians and other health professionals have with their patients regarding end-of-life care and patient preferences.

Advance Care Planning involves multiple steps designed to help individuals:

- Learn about health care options and decisions for end-of-life care.
- Determine which type of care best fit their personal wishes.
- Share wishes with family, friends, designated advocate and physicians.

Advance Care Planning is offered as a separate service from the current primary office visit coverage; the visit does not count toward your annual office visit limit, if applicable.
Please note, applicable office visit copay may apply.

MANDATORY MEDICARE PART A ENROLLMENT

All Trust members who are eligible are required to have Medicare Part A to be enrolled in Trust coverage.

All Trust members **must** enroll in Medicare Part A at age 65. If the member does not enroll, he or she will no longer be eligible for enrollment in Trust coverage. Most Trust members are **automatically** enrolled in Medicare Part A when they turn age 65.

Medicare plays a significant role in providing coverage for Trust members. Trust benefits coordinate with Medicare benefits for eligible members. Trust coverage works with Medicare Part A (hospital) and Part B (Medical). If you are not enrolled in both when eligible, it could significantly impact your Trust coverage and options. For Members who are enrolled in Medicare Parts A and B, you may also have Medicare Advantage Plan (Part C) options in your area. The Trust will automatically enroll Medicare members in Express Scripts Medicare PDP (Part D) for prescription drug coverage.

For additional information regarding Trust eligibility and rules on Medicare coverage, refer to your Summary Plan Description (SPD) or visit www.uawtrust.org.

HEALTH COVERAGE OUTSIDE OF THE U.S.

The Trust will only pay for health care claims outside of the United States if they are urgent or an emergency. There is no coverage for routine care. Because your health care coverage is limited outside the U.S., you may choose to buy a travel insurance policy to get more coverage. An insurance agent or travel agent can provide you with more information about buying travel insurance.

OTHER BENEFIT CHANGES

Medicare has revised its policies to discontinue coverage for individuals who are in the U.S. illegally. As a result, effective January 1, 2017, members who are living in the U.S. illegally will be disenrolled from all Trust coverage when they become entitled to Medicare (most of the time when reaching age 65). Members who are in the U.S. legally because of a visa, marriage, citizenship, etc. will not experience any change from this.

The government recently established rules concerning coverage provided to individuals who experience gender dysphoria (or gender identity disorder). As a result, the Trust is removing the exclusions attached to those members who experience gender dysphoria and require surgical and pharmaceutical therapy to assist that condition. Members requiring these services after January 1, 2017, should contact their carrier for more information on any prerequisites and coverage limitations.

IMPORTANT CONTACT INFORMATION

CALL CENTERS		
Retiree Health Care Connect	**866-637-7555**	
Pension Administrator	**800-248-4444 (National Employee Services Center)**	
Medicare CMS/Centers for Medicare and Medicaid Services	**Medicare Service Center: 800-MEDICARE (800-633-4227)** **Medicare Service Center TTY: 877-486-2048**	

HEALTH PLAN CARRIERS	HEALTH PLAN CARRIERS	HEALTH PLAN CARRIERS
Aetna Medicare Advantage PPO 800-663-0885	**Delta Dental** 800-524-0149	**Kaiser Permanente - Colorado** Non-Medicare Members: 800-632-9700 Medicare Members: 800-476-2167
AudioNet America (administered by SVS) 877-500-7370	**Express Scripts** (Prescription Drug Coverage) 866-662-0274	**Kaiser Permanente - Georgia** Non-Medicare Members: 888-865-5813 Medicare Members: 800-232-4404
Beacon Health Systems (formerly ValueOptions) 877-228-3912	**Green Shield** (Canadian Health Plan) 888-711-1119	**Kaiser Permanente – Mid-Atlantic** 800-777-7902
Blue Care Network (BCN) 800-222-5992	**Health Alliance Plan (HAP)** Non-Medicare Members: 800-422-4641 Medicare Members: 800-801-1770	**Kaiser Permanente - Northwest** 800-813-2000
Blue KC Non-Medicare Members: 866-579-0864 Medicare Members: 866-508-7140	**HealthPartners of Minnesota** 800-883-2177	**Midwestern Dental** 800-544-6374
Blue Cross Blue Shield Medicare Advantage PPO 888-322-5616	**Humana Medicare Advantage PPO** 800-758-5002	**SVS Vision** 800-225-3095
Blue Cross Blue Shield Traditional Care Network (TCN) 877-832-2829	**Humana Non-Medicare PPO** 800-758-5002	**TheraMatrix Physical Therapy** 888-638-8786
Coventry Health Care of Missouri Non-Medicare Members: 800-755-3901 Medicare Members: 800-533-0367	**Kaiser Permanente - California** Non-Medicare Member: 800-464-4000 Medicare Members: 800-443-0815	**UnitedHealthcare Medicare Advantage PPO** 877-776-1469

If there is any conflict between this document and previously published documents, the plan document will govern. The committee reserves the right to interpret, amend or terminate the plan of health care benefits at any time.