2019 HEALTH CARE BENEFITS SUMMARY FOR UAW-FORD RETIREES

THE FOLLOWING INFORMATION IS AN ADDENDUM TO THE SUMMARY PLAN DESCRIPTION (SPD) PUBLISHED IN 2015. Unless otherwise noted, the information contained in this package is effective January 1, 2019.

Dear Trust Member,

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

The Trust's objective is to provide you with tools to make informed decisions about your health and health care plan options. The information in this package will assist you in making these decisions, as well as serve you in the future by providing information on your benefits and important contact information.

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

This document, along with other helpful information, is available at **uawtrust.org**. We continue to update our website in order to make it a valuable resource. Online, you can find documents for download, wellness information, and videos detailing the history, structure, and funding of the Trust, as well an overview of each year's benefits.

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 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.

Contents

If you are enrolled in an HMO or Medicare Advantage plan, the health plan carrier will provide you a booklet, such as an "Evidence of Coverage" or "Certificate of Coverage," describing the detailed terms of your coverage and the rules that govern your particular health plan. If you have questions about the information, contact Retiree Health Care Connect (RHCC) at 866-637-7555 or your health plan carrier.

Pension Deduction

Most Trust members are required to make a monthly contribution to the Trust for health care benefits.

Your contribution 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 contribution, 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

The monthly contribution amount that will be deducted from your pension may change annually and varies based on the plan type you are enrolled in.

MEDICARE MEMBERS			
PLAN TYPE	**MA PPO** Medicare Advantage PPO	**TCN** Traditional Care Network	**HMO** Health Maintenance Organization
MONTHLY CONTRIBUTION	$0 Single $0 Family	$17 Single* $34 Family*	$0 Single $0 Family

NON-MEDICARE MEMBERS		
PLAN TYPE	**ECP** Enhanced care PPO	**HMO** Health Maintenance Organization
MONTHLY CONTRIBUTION	$17 Single* $34 Family*	$17 Single* $34 Family*

*Protected Population: Single or Family $0.

Health Plans

Health Plans Types

As a new retiree or surviving spouse, your health plan options and/or benefits may have changed. Depending on your geographic location and Medicare status, you may have multiple plan options available to you, including the Enhanced Care PPO (ECP) plan, a Health Maintenance Organization (HMO) plan, the Traditional Care Network (TCN), and a Medicare Advantage (MA) plan.

Non-Medicare Members

The **Enhanced Care PPO (ECP) plan is the primary plan** for non-Medicare Trust member (under age 65 and without disability). This plan is available in all 50 states. Based on geographical location, there may be additional health plan options available.

Medicare Members

The **Medicare Advantage (MA) PPO plan is the primary plan** for Medicare-enrolled Trust member (over age 65, or on Medicare because of a disability). Medicare-enrolled members are automatically enrolled in the MA PPO plan on January 1, following the year they qualify for Medicare. The Blue Cross Blue Shield Traditional Care Network (TCN) plan remains an option but members have to contact RHCC to remain in the TCN plan following Medicare eligibility. Certain Medicare members, such as Protected Status members and those enrolled in an HMO plan will not be automatically enrolled in the MA PPO plan but have the option to select the plan.

Mandatory Medicare Part A Enrollment

All Medicare-eligible individuals are required to have Medicare Part A to enroll/maintain enrollment in Trust coverage, otherwise, they will not be eligible for Trust coverage. Most individuals are automatically enrolled in Medicare Part A when they turn age 65.

Medicare plays a significant role in providing coverage for Medicare-eligible Trust members. Trust benefits coordinate with Medicare Part A (hospital) and Part B (medical) benefits. If you are not enrolled in both when eligible, it could significantly affect your Trust coverage and options. The Trust will automatically enroll Medicare-enrolled 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). To learn more about your choices or to make plan election changes, contact **Retiree Health Care Connect (RHCC) at 866-637-7555**.

Mandatory 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 (ESRD) 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 this 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.

Cost Share & Copays

Trust assets 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 member contributions.

Medicare Members

Primary Plan: Medicare Advantage (MA) PPO

The MA PPO plan is the primary plan for Trust Medicare members. This plan type is approved by Medicare and administered by private insurance companies. This plan provides all of Original Medicare Part A (hospital) and Part B (medical) benefits and provides additional benefits. The MA PPO plan uses a nationwide network of doctors and facilities, and allows services to be performed both in-and out-of-network. To stay eligible for this plan, you must continue to pay your monthly Medicare Part B premium.

Traditional Care Network (TCN)

This is a plan option available nationally to Medicare members only. Based on a nationwide network of providers, the TCN plan allows services to be performed both in- and out-of-network. With this plan, Medicare is primary and TCN coverage is secondary.

Health Maintenance Organization (HMO)

This is a plan option available to Medicare (and non-Medicare) members who are in the regions where they are offered. An HMO plan utilizes a regional network of doctors and facilities and does not typically allow non-emergency services to be performed out-of-network. Regions (based on zip code) within these states have HMO plan offerings available: California, Colorado, Georgia, Maryland, Michigan, Minnesota, Oregon, Washington D.C., Washington (state), and Virginia.

MEDICARE MEMBERS			
	MA PPO Medicare Advantage PPO	**TCN** Traditional Care Network	**HMO** Health Maintenance Organization
DEDUCTIBLE (amount you pay annually before the plan begins to pay a portion of the cost)	$245 / Person	$400 Single $675 Family	$400 Single* $675 Family*
COINSURANCE (amount you pay after your deductible is met)	10%	10%	N/A
OUT-OF-POCKET MAX (total amount you pay annually before the plan covers 100% of covered costs)	$630 / Person	$800 Single $1,475 Family	N/A
PRIMARY CARE PHYSICIAN (PCP) OFFICE VISIT	$20 Copay	Covered by Medicare at 80%, after Part B deductible is met; *Member pays remaining 20%*	$25 Copay
SPECIALIST OFFICE VISITS	$25 Copay	Covered by Medicare at 80%, after Part B deductible is met; *Member pays remaining 20%*	$35 Copay*
URGENT CARE (including Retail Health Clinics)	$25 Copay	$50 Copay	$25 Copay
EMERGENCY ROOM (waived if admitted)	$50 Copay	$125 Copay	$50 Copay

*Does not apply to the Protected Population. (See plan materials for actual costs.)

Non-Medicare Members

Primary Plan: Enhanced Care PPO (ECP)

The ECP plan is the primary plan for Non-Medicare members. Based on a nationwide network of providers, the ECP plan allows services to be performed both in-and out-of-network. In addition to providing unlimited PCP office visit and specialist coverage, the ECP plan features personalized and convenient resources to assist you in navigating the health care system. With this plan, you will have access to a personal health guide who can help find hospitals and doctors, answer questions about what's covered under the plan, assist with provider billing questions, as well as connect you to a supporting team of clinical staff, care managers, and specialized programs. Only non-Medicare members are eligible for this plan.

Health Maintenance Organization (HMO)

This is a plan option available to non-Medicare (and Medicare) members who are in the regions where they are offered. An HMO plan utilizes a regional network of doctors and facilities and does not typically allow non-emergency services to be performed out-of-network. Regions (based on zip code) within these states have HMO plan offerings available: California, Colorado, Georgia, Maryland, Michigan, Minnesota, Oregon, Washington D.C., Washington (state), and Virginia.

NON-MEDICARE MEMBERS		
	ECP Enhanced Care PPO	**HMO** Health Maintenance Organization
DEDUCTIBLE (amount you pay annually before the plan begins to pay a portion of the cost)	$400 Single $675 Family	$400 Single* $675 Family*
COINSURANCE (amount you pay after your deductible is met)	10%	N/A
OUT-OF-POCKET MAX (total amount you pay manually before the plan covers 100% of covered costs)	$800 Single $1,475 Family	N/A
PRIMARY CARE PHYSICIAN (PCP) OFFICE VISIT	$25 Copay	$25 Copay
SPECIALIST OFFICE VISITS	$35 Copay	$35 Copay*
URGENT CARE (including Retail Health Clinics)	$50 Copay	$50 Copay
EMERGENCY ROOM (waived if admitted)	$125 Copay	$125 Copay*

*Does not apply to the Protected Population. (See plan materials for actual costs.)

Prescription Drug Benefits

Most Trust medical plans have prescription drug coverage administered by **Express Scripts** (excluding select HMO plans). Regardless of the medical plan option you are enrolled in, the copay amounts for prescription drug benefits are the same.

Learn more: uawtrust.org/prescriptiondrugcoverage

COPAYS FOR ALL PLANS		
	Retail (one month supply)	**Mail-Order** (90-day supply)
TIER 1 GENERIC	$14	$24
TIER 2 PREFERRED BRAND	$45	$85
TIER 1 NON-PREFERRED BRAND	$115	$230

Hearing Aid Coverage

HEARING AID COVERAGE ADMINISTRATOR		
	Plan Option	**Administrator**
BLUE CROSS BLUE SHIELD (BCBS)	Medicare TCN Members / Non-Medicare ECP Members	AudioNet America (see details on the following page)
HMO PLANS	Medicare & Non-Medicare HMO Members	See plan materials for coverage detail
MA PPO PLANS	All MA PPO Plan Members	AudioNet America (see details on the following page)

AudioNet America Coverage Detail

For members with coverage though AudioNet America, hearing aid services must be performed by an in-network participating provider to receive full coverage. Call AudioNet America for assistance with finding an in-network provider: 877-500-7370.

AUDIONET HEARING: BENEFITS AT-A-GLANCE		
	Participating Provider	**Frequency**
AUDIOMETRIC EXAMINATION	Covered in full	Once every 36 months
HEARING AID EVALUATION TEST (including conformity evaluation)	Covered in full	Once every 36 months, per year
DIGITAL HEARING AIDS (including acquisition costs and dispensing fees)	Covered in full: Two (2) mid-level standard digital hearing aids	Once every 36 months, per year
REPLACEMENT MOLDS (for children up to age 7)	Covered in full	- No more than 4 replacements annually for children up to age 3 - No more than 2 replacements annually for children ages 3 – 7
EAR MOLDS (enrollees over age 7)	First set only is covered in full	First set is included with the initial hearing aid
ACCESSORIES	No coverage	No coverage
MAINTENANCE / FITTING / FOLLOW-UP VISITS	Covered in full: Within six (6) months Thereafter: $20 copay	Covered in full: Within six (6) months Thereafter: $20 copay

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 a 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

Health Programs

The Trust recognizes the important role health education programs play in managing your overall health and well-being. In addition to other programs your specific health plan may provide, there are programs available to you. For details about each program and specific information about enrollment, contact your health plan carrier.

ADDITIONAL HEALTH PROGRAMS		
	Description	**Benefits**
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.	Must begin within 3 months of a cardiac event and be completed within 6 months. The benefit covers up to 36 sessions (3 sessions per week for 12 weeks) covered at 100% up to the allowed amount.
DIABETES EDUCATION	Covers comprehensive, American Diabetes Association-approved education classes for newly-diagnosed or uncontrolled diabetics.	Classes taught by certified diabetes educators covering 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

Advanced Care Planning Office Visit

Advance Care Planning is a discussion between a physician (or other health professionals) and a patient regarding end-of-life care and patient preferences. The Trust covers Advance Care Planning under all health plans.

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 fits personal wishes.
- Share wishes with family, friends, designated advocate, and physicians.

The applicable office visit copay may apply for this visit.

Health Coverage Outside of the U.S.

The Trust will only pay for healthcare claims outside of the U.S. 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, members living in the U.S. illegally will be disenrolled from all Trust coverage when they become entitled to Medicare (generally when reaching age 65). Members in the U.S. legally (because of a visa, marriage, citizenship, etc.) will not experience any change.

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

Important Contact Information

HEALTH PLANS		
MEDICARE		
AETNA MEDICARE ADVANTAGE (MA) PPO	800-663-0885	National, except MI
BLUE CROSS BLUE SHIELD (BCBS) MEDICARE ADVANTAGE (MA) PPO	877-832-2829	AL, FL, IN, MI, MO, TN
BLUE CROSS BLUE SHIELD (BCBS) TRADITIONAL CARE NETWORK (TCN) *WITH MEDICARE AS PRIMARY*	888-322-5616	National
NON-MEDICARE		
BLUE CROSS BLUE SHIELD ENHANCED CARE PPO (ECP)	866-507-2850	National

For contact information for other health plans that may be available depending on your regional location, visit **uawtrust.org/healthplancarriers** or call the number on the back of your medical ID card.

OTHER	
TRUST BENEFIT NEWS	
UAWTRUST.ORG	Features the latest news on your health and prescription drug benefits, health and wellness information, downloadable document center, ways to contact us, and more.
CALL CENTERS	
RETIREE HEALTH CARE CONNECT (RHCC)	866-637-7555
MEDICARE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	800-MEDICARE (800-633-4227)
PHARMACY	
EXPRESS SCRIPTS	866-662-0274
DENTAL	
DELTA DENTAL	800-524-0149
VISION	
DAVIS VISION	888-234-5164
HEARING	
AUDIONET AMERICA	800-400-2619

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.