



Protected

UAW RETIREE
Medical Benefits Trust

2020 HEALTH CARE BENEFITS SUMMARY FOR PROTECTED UAW-GM 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, 2020.

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 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.

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.

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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.

Eligibility

Effective January 1, 2020, the Trust expanded the eligibility criteria for the Protected member category to include all retirees who retired before October 1, 1990, and all surviving spouses of retirees who retired before October 1, 1999. Cost share is different for Protected members.

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, contact RHCC at 866-637-7555 to enroll in the direct debit option.

Monthly Contribution

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

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

NON-MEDICARE MEMBERS		
PLAN TYPE	ECP Enhanced Care PPO	HMO Health Maintenance Organization
MONTHLY CONTRIBUTION	\$17 Single \$17 Family	\$17 Single \$17 Family

Health Plans

Health Plans Types

As a new Protected 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.

As a Protected member, you have access to the same plan options as a General member but depending on which plan you choose, you can see significantly lower out-of-pocket costs.

Non-Medicare Protected Members

The **Enhanced Care PPO (ECP) plan is the primary plan** for all non-Medicare Trust members (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 Protected Members

Medicare-enrolled (over age 65, or on Medicare because of a disability) members have the option to enroll in the **Protected Medicare Advantage (MA) PPO 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 **RHCC at 866-637-7555**.

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

Medicare Advantage (MA) PPO

The Protected MA PPO plan is a cost savings plan option for Protected 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 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

	Protected MA PPO Medicare Advantage PPO	TCN Traditional Care Network	MA HMO Health Maintenance Organization
DEDUCTIBLE (amount you pay annually before the plan begins to pay a portion of the cost)	\$0 / Person	\$400 Single \$675 Family	\$0 Single or 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	\$0 Copay	Covered by Medicare at 80%, after Part B deductible is met; <i>Member pays remaining 20%</i>	\$25 Copay
SPECIALIST OFFICE VISIT	\$0 Copay	Covered by Medicare at 80%, after Part B deductible is met; <i>Member pays remaining 20%</i>	\$25 Copay
URGENT CARE (including Retail Health Clinics)	\$25 Copay	\$50 Copay	\$25 Copay
EMERGENCY ROOM (waived if admitted)	\$50 Copay	\$125 Copay	\$50 Copay

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	\$0 Single or Family
COINSURANCE (amount you pay after your deductible is met)	10%	N/A
OUT-OF-POCKET MAX (total amount you pay annually before the plan covers 100% of covered costs)	\$800 Single \$1,475 Family	N/A
PRIMARY CARE PHYSICIAN (PCP) OFFICE VISIT	\$25 Copay	\$25 Copay
SPECIALIST OFFICE VISIT	\$35 Copay	\$25 Copay
URGENT CARE (including Retail Health Clinics)	\$50 Copay	\$50 Copay
EMERGENCY ROOM (waived if admitted)	\$125 Copay	\$100 Copay

Prescription Drug Benefits

Most Trust medical plans have prescription drug coverage administered by **Express Scripts** (excluding Kaiser Permanente and HealthPartners plans). If your coverage is through Kaiser Permanente or HealthPartners, please review your plan materials for prescription drug copay amounts.

Below is the cost share amounts for Express Scripts.

Learn more: uawtrust.org/prescriptiondrugcoverage

COPAYS FOR ALL PLANS		
	Retail (one month supply)	Mail-Order (90-day supply)*
TIER 1 SELECT GENERIC	\$5	\$5
TIER 2 PREFERRED BRAND	\$45	\$45
TIER 1 NON-PREFERRED BRAND	\$115	\$115

*Specialty medications are dispensed in one-month increments.

Out-of-Pocket Prescription Copay Maximum

Effective January 1, 2020, an annual out-of-pocket copay maximum of \$1,500 will be in place for all tier 1 and tier 2 drugs to limit expenses for members on multiple medications. Tier 3 medications are excluded, as there are lower cost options available in tier 1 and tier 2.

Davis Vision

Effective January 1, 2019, coverage through Davis Vision includes three enhancements:

1. Two-year eyeglass breakage warranty—all new eyeglass purchases beginning 1/1/2019 will have this coverage.
2. 100% coverage on certain standard progressive lenses. Members should check with their eye care provider for which brands and lens types are covered.
3. Costco is in-network. Members can obtain services at Costco (must be a Costco member).

These features were added to member coverage automatically at no additional cost.

TruHearing

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

TruHearing Coverage

Effective May 1, 2019, members enrolled in the BCBS ECP, TCN, MA PPO and Aetna MA PPO plans have hearing administered through TruHearing. For these members, hearing aid services must be performed by an in-network participating provider to receive full coverage. For assistance:

1. Call TruHearing to speak to a hearing consultant: 844-394-5420
2. TruHearing sets up an appointment with a provider near you
3. Provider conducts thorough hearing exam, fits and trains you on the hearing aids

TRUHEARING: BENEFITS AT-A-GLANCE

	Description/Frequency	Cost Share*
HEARING EXAM	Once every 36 months	\$0
HEARING AID EVALUATION TEST	Once every 36 months	\$0
CONFORMITY EVALUATION	Once every 36 months	\$0
COVERED HEARING AIDS (INCLUDING DISPENSING FEE) ELIGIBLE FOR ONE (1) HEARING AID PER EAR EVERY 36 MONTHS	Mid-Level Mid-High Level Advanced Level Flagship Level	\$0 per hearing aid \$250 per hearing aid \$500 per hearing aid \$650 per hearing aid
INITIAL HEARING AID FITTING	Initial fitting and programming of purchased hearing aid	\$0
FOLLOW-UP VISITS	Provider visits after initial hearing aid fitting	First 6 months: \$0 After 6 months: \$20 per visit
BATTERIES	48 batteries included with purchase of each non-rechargeable hearing aid	\$0

45-DAY HEARING AID TRIAL PERIOD	Hearing aid may be returned or exchanged for 45 days following initial hearing aid fitting	\$0 (additional charges may apply if hearing aid is exchanged for a more expensive hearing aid)
WARRANTY AND REPLACEMENT DEVICES – MANUFACTURER DEFECT	Repair or replacement of hearing aid due to manufacturer defect (3-year warranty)	\$0
WARRANTY AND REPLACEMENT DEVICES – LOSS AND DAMAGE	Repair or replacement of hearing aid due to loss or damage (3-year warranty); available once per hearing aid	\$225 deductible per hearing aid
INITIAL EAR MOLDS	Covered with purchase of hearing aid styles that require ear molds	\$0
REPLACEMENT EAR MOLDS (CHILDREN UP TO AGE 7)	Children up to age 3: up to four (4) replacement ear molds each year Children ages 3-7: up to two (2) replacement ear molds each year	\$0 (cost of additional ear molds is your responsibility)
REPLACEMENT EAR MOLDS (ENROLLEES OVER AGE 7)	Not covered	N/A

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

Exclusions

The following items and services are not covered under your plan benefits:

- Services and equipment obtained from out-of-network providers exceeding the discounted (reimbursement) amount for hearing aid services that would have been paid if service(s) were obtained in-network
- Any products not listed on the approved product list
- 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 60 days after termination of coverage
- Charges for services available under the TruHearing benefit which are offered at no charge or for which there would be no charge if not covered under the TruHearing benefit
- Charges for audiometric examinations, hearing aid evaluation tests, and hearing aids which do not follow accepted standards of professional practice, including, but not limited to, where the services are not necessary or where the services are experimental
- 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 or 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 for a warranty replacement or new hearing aids
- 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 7, unless otherwise covered under a warranty
- Charges incurred by a person enrolled in a plan that does not have access to the TruHearing benefit
- Eyeglass-type or eyeglass mounted hearing aids
- Charges for failure to keep a scheduled visit with a provider
- Charges for "spare" hearing aids (i.e., more than one (1) hearing aid per ear every 36 months)
- 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) 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 advocates, 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 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) <i>WITH MEDICARE AS PRIMARY</i>	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	
TRUHEARING	844-394-5420

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 health care benefits at any time.