UAW RETIREE Medical Benefits Trust

2020-21 Schedule of Benefits for General Motors Protected Members

The Schedule of Benefits is an addendum to the most current Summary Plan Description.

Medical Plan Provisions for General Motors Protected Members

The following table outlines the medical plans offered by the UAW Retiree Medical Benefits Trust. The amounts may be adjusted as determined by the Committee.

Express Scripts Prescription Drug Copayments*

	Retail Pharmacy (Fills for 1-Month Supply)	Mail Order Pharmacy (Fills for 90-Day Supply)
Tier 1: Generic	$5	$5
Tier 2: Preferred Brand (and Select Generics)	$45	$45
Tier 3: Non-Preferred Brand	$115	$115

*Members enrolled in Kaiser or HealthPartners do not have pharmacy coverage through Express Scripts. Copay amounts are different for these plans. See plan materials for copay amounts. All other prescription drug coverage provided by Express Scripts.

Please be advised that the eligibility rules of the Plan determine your eligibility for Protected status. This mailing is not intended to amend, modify or otherwise change the Plan's eligibility rules or your eligibility for Protected status. If you have questions about your eligibility for Protected status or if you received this mailing in error please contact RHCC at 866-637-7555.

MEDICARE

2020-21

Medicare Advantage PPO

Monthly Contribution
$0

	(In-Network)	(Out-of-Network)
Deductible (Amount you pay annually before the plan begins to pay a portion of the costs)	$0	$490 per person
Coinsurance (Amount you pay after your deductible is met)	0%	30%
Out-of-Pocket Max (Total amount you pay annually before the plan covers 100% of covered costs)	$0	$1,395 per person
Primary Care Physician (PCP) Office Visit	$0	50% coinsurance after the deductible
Specialist Office Visit	$0	50% coinsurance after the deductible
Urgent Care (Including Retail Health Clinics)	$25 per visit	$25 per visit
Emergency Room (Waived if admitted)	$50 per visit	$50 per visit

MEDICARE 2020-21

	TCN Monthly Contribution $17 Single | $17 Family		HMO* Monthly Contribution $0
	(In-Network)	(Out-of-Network)	
Deductible (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	$0
Coinsurance (Amount you pay after your deductible is met)	10%	30%	N/A
Out-of-Pocket Max (Total amount you pay annually before the plan covers 100% of covered costs)	$800 Single $1,475 Family	$3,000 Single $5,550 Family	N/A
Primary Care Physician (PCP) Office Visit	Covered by Medicare at 80%, after Part B deductible is met; You pay remaining 20%	No Coverage	$25 per visit
Specialist Office Visit	Covered by Medicare at 80%, after Part B deductible is met; You pay remaining 20%	No Coverage	$25 per visit
Urgent Care (Including Retail Health Clinics)	$50 per visit	No Coverage	$25 per visit
Emergency Room (Waived if admitted)	$125 per visit	$125 per visit	$50 per visit

*HMO plan may vary by region. Not available in all areas. No coverage out-of-network.

NON-MEDICARE

2020-21

	ECP Monthly Contribution $17 Single | $17 Family		HMO* Monthly Contribution $17 Single $17 Family
	(In-Network)	(Out-of-Network)	
Deductible (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	$0
Coinsurance (Amount you pay after your deductible is met)	10%	30%	N/A
Out-of-Pocket Max (Total amount you pay annually before the plan covers 100% of covered costs)	$800 Single $1,475 Family	$3,000 Single $5,550 Family	N/A
Primary Care Physician (PCP) Office Visit	$25 per visit	No Coverage	$25 per visit
Specialist Office Visit	$35 per visit	No Coverage	$25 per visit
Urgent Care (Including Retail Health Clinics)	$50 per visit	No Coverage	$50 per visit
Emergency Room (Waived if admitted)	$125 per visit	$125 per visit	$100 per visit

*HMO plan may vary by region. Not available in all areas. No coverage out-of-network.

DENTAL COVERAGE

Dental coverage is provided through Delta Dental. The dental coverage offered by the Plan varies by provider's participation in the network. By going to a PPO dentist, you will have the lowest cost-sharing. Here is a summary of the benefit and applicable percentage of cost-sharing.

Routine, Diagnostic and Emergency Services

Service	PPO Dentist	Premier Dentist	Non-Participating Dentist
Exams, Cleanings (Routine or Periodontal Twice per year), **Fluoride Treatment**	100%	100%	100%
Emergency Treatment	100%	100%	100%
X-Rays	100%	90%	90%

All Other Services

Service	PPO Dentist	Premier Dentist	Non-Participating Dentist
Fillings (Non-white; Metallic)	100%	90%	90%
Endodontic (Root Canals), **Periodontic** (Gum Disease), **Extractions** (Removal of Teeth), **Relines and Repair Services** (to Dentures, Bridges, and Implants)	100%	90%	90%
Major Restorative (Crowns) **or Other Oral Surgery**	90%	90%	90%
Prosthodontic Services (Bridges and Dentures)	70%	50%	50%
Orthodontic Services (Braces) **Treatment must begin prior to age 19**	60%	50%	50%
Orthodontic Lifetime Maximum	$2,000 per person		
Annual Plan Maximum	$1,700 per person		

HEARING COVERAGE

Hearing coverage is provided through TruHearing. Services only available through audiologists in TruHearing's network. Here is a summary of the benefit and applicable cost-sharing.

Item/Service	Description/ Frequency	Your Cost Share*
Hearing Exam	Once every 36 months	$0
Hearing Aid Evaluation Test	Once every 36 months for each ear	$0
Conformity Evaluation	Once every 36 months for each ear	$0
Covered Hearing Aid (Including dispensing fee) **Eligible for one** (1) **hearing aid per ear every 36 months**	Mid-Level Mid-High Level Advance 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 visit after inital 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

**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.*

HEARING COVERAGE

Item/Service	Description/ Frequency	Your Cost Share*
Initial Ear Molds (children up to age 7)	Covered with purchase of hearing aid styles that require ear molds	$0
Initial Ear Molds (enrollees over age 7)	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	Full cost of additional ear molds

** 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.*

VISION COVERAGE

Vision coverage is provided through Davis Vision. Here is a summary of the benefit and applicable cost-sharing for in-network providers.

Service	In-Network Coverage
Routine Vision Exam	Covered in Full Every 12 Months
Re-examination by Ophthamologist (within 60 days of initial Optometrist examination, when medically necessary and with a referral)	$45 Allowance Towards Total Cost
Standard Lenses (Glass or Plastic) • **Single Vision** • **Lined Bifocal/Trifocal** • **Standard Progressive Addition Lenses[2]** • **Special** (Lenticular, Aspheric, etc.)	Covered in Full Every 24 Months
Davis Vision Collection Frames	Covered in Full Every 24 Months
Frames from Provider Selection	$40 Allowance Every 24 Months
Contact Lens Evaluations, Fitting and Follow Up Care (Instead of Glasses)	$40 Allowance Every 24 Months
Contact Lenses (Instead of Glasses)	$75 Allowance Every 24 Months
Medically Necessary Contact Lenses	$350 Allowance Every 24 Months

Coverage through Davis Vision also includes the following enhancements:

1. Two-year eyeglass breakage warranty – all new eyeglasses purchased after January 1, 2019, 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.)

Dental, hearing and vision plans do not cover all expenses and include limitations and exclusions. Please refer to your carrier's plan documentation to determine which services are covered and to what extent.