TRANSITION OF MEDICAL BENEFITS TO THE UAW TRUST

A REFERENCE AND RESOURCE GUIDE FOR UAW UNION BENEFITS REPRESENTATIVES

This guide provides information on benefits under the UAW Retiree Medical Benefits Trust (the "Trust"). The information included further describes the various life cycle stages of medical and prescription drug benefits for eligible UAW retirees and their eligible dependents. This guide is a supplement to the Summary Plan Description (SPD), Health Care Benefits Summary and Benefit Highlights; therefore, in cases where discrepancies exist, the Plan Document will rule.

This guide is intended for Union Benefits Representatives only.

Updated: January 2019

Contents

The UAW Retiree Medical Benefits Trust (VEBA)

The UAW Retiree Medical Benefits Trust is the official name of the Voluntary Employee Beneficiary Association (VEBA) responsible for providing UAW retirees of GM, Ford and Chrysler with medical and prescription drug benefits. It is also referred to as the UAW VEBA, UAW Trust or in most documents and for the purpose of this guide "the Trust."

The **mission** of the Trust is to provide every member with health benefits and the opportunity to achieve their best quality of life.

Our **vision** is to advocate for the health and wellbeing of our members and drive improvement in quality and access to affordable care.

What is a VEBA?

A VEBA is a trust holding funds to meet the cost of health and welfare benefits. A trust can be funded by employer contributions, employee contributions or both. VEBAs established under collective bargaining agreements benefit from tax-deductible contributions and tax-free accumulation of earnings. Section 501 (c) (9) of the Internal Revenue code establishes a VEBA's tax-exempt status.

A VEBA must be an "employees' association"–a group of employees who associate together to receive benefits and have an "employment-related common bond." The UAW Trust is a bit different, as it is comprised of three "EBAs" (employees' beneficiary associations)–one for each automotive company.

History

The UAW Trust was created as a result of the 2007 UAW Settlement Agreements with GM, Ford, and Chrysler. The UAW and respective automotive companies negotiated terms to establish a VEBA to take over responsibility for the administration and delivery of medical benefits beginning January 1, 2010. These Agreements were reviewed and approved by the federal courts.

The 2007 Settlement Agreements eliminated a series of "all-or-nothing" risks that previously threatened the very existence of ongoing medical benefits for UAW retirees. Under the Agreements, however, the Committee is responsible to make sure, on an on-going basis, the assets of the Trust are in line with benefit levels.

For more information on the history, structure and funding of the Trust, visit uawtrust.org/videos.

An Independent Trust

The UAW Trust is an independent Trust, not operated by the UAW, with oversight provided by 11 Committee Trustees (six independent representatives who are court approved, and five UAW-affiliated representatives). Many Trustees also serve on the Audit, Investment, Plan Administration and Vendor Performance Subcommittees.

Separate Funding, Shared Administration

The Committee is responsible for designing and delivering medical benefits to eligible UAW retirees, surviving spouses and dependents. To provide benefits, the Committee can use only assets available in the VEBA Trust fund. The Trust is required to maintain three separate accounts, one each for GM, Ford and Chrysler retirees. Health care benefits for retirees can only be paid from the account associated with the auto they retired from and cannot be paid out of the accounts set up for retirees from the other two companies.

On an on-going basis, the Committee reviews Trust asset levels compared with benefit costs and makes adjustments to plan design and benefit levels, as needed. Adjustments to benefits are typically made on a calendar year basis, and retirees are notified in the fall of the year before any change takes effect. Benefits Representatives are notified of all member communications prior to member distribution so they can answer questions and help retirees understand the background of these changes in advance.

Financial Reporting

Each December, the Trust mails members the Summary Annual Report (SAR) for their respective auto group, which is required by law. This document provides information about the Trust's financial status from the prior calendar year. Members can download the SAR at uawtrust.org/documents or request a copy by contacting Retiree Health Care Connect (RHCC) at 866-637-7555.

Transitioning to Trust Medical Benefits

Pre-Retirement & Retirement Initiation

Since, upon retirement, health care coverage is transferred to the Trust, a separate entity from the auto company, the retirement process should begin at least 90 days prior to the intended effective date. It is important future members understand that Trust coverage differs from active coverage in several ways:

- Monthly contributions may be required.
- Dependent eligibility rules differ.
- Carriers and plan options may be different.
- Blue Cross Blue Shield plans plans have deductibles, copays and out-of-pocket maximums.
- HMO plans (where available) have deductibles.
- Benefit coverage differs.
- Dental and vision plans may have coverage differences.
- Prescription drug copays are higher.

Note: Additional information can be found in the SPD, Health Care Benefits Summary, and Benefit Highlights, available for download at uawtrust.org/document.

As a new retiree or surviving spouse, a member's health plan options and/or benefits may have changed. Depending on their geographic location and Medicare status, they may have multiple plan options available.

Non-Medicare Members

If at the time of retirement a non-Medicare member's current health plan is available, all data, including dependent information will automatically transfer to that plan. If the health plan is not available, the retiree and any dependents (those not enrolled in Medicare Part A) will be transferred to the Blue Cross Blue Shield Enhanced Care PPO (ECP) plan.

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, such as an HMO plan option.

Medicare Members

Medicare Part A Enrolled Members: Age 65 or older and/or Under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

If at the time of retirement, a member or dependent is enrolled in Medicare Part A, he or she will need to enroll in Medicare Part B for an effective date matching the retirement date, in order to receive benefits from the Trust. Please note: if a member is eligible for and/or entitled to Medicare, benefits under the Trust plan will be paid as if the member had Medicare coverage whether or not he or she chooses to enroll in Medicare. There is no exception based on timing so it will be important that the Medicare effective date match the retirement date.

If the member's current health plan is available, all data will automatically transfer to that plan. If the health plan is not available, the retiree and any dependents will be transferred to the Blue Cross Blue Shield Traditional Care Network (TCN) plan. On January 1 of the following calendar year, the Medicare Advantage (MA) PPO plan will become the primary plan. This means the member will be automatically enrolled in the MA PPO plan unless they make another plan option choice by contacting RHCC. If at the time of retirement, a member's Part B information is on file, they may elect to enroll in the MA PPO plan, if they choose.

The **Medicare Advantage (MA) PPO plan is the primary plan** for Medicare-enrolled Trust member. The Blue Cross Blue Shield Traditional Care Network (TCN) plan remains an option. 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.

All retirees will receive new ID cards from the health plan carriers.

Most plans require a monthly contribution. For members enrolled in Medicare Advantage plans (either PPO or HMO), there are no monthly contributions. Monthly contributions are set for an automatic pension deduction unless otherwise indicated or if sufficient funds are not available. Members unable to have their monthly contributions deducted from their monthly pension payments are encouraged to sign up with RHCC for direct debit to avoid a disruption in health care coverage.

Retirees should also be aware that deductibles and copayments for the health plans may be different than those of active employees. A Welcome Book, Summary Plan Description, Health Care Benefits Summary and current Benefit Highlights are sent to new retirees upon receipt of retirement info at RHCC.

Transition Process

- ✓ Retiree alerts auto of retirement by contacting UAW Benefits Representative.
- ✓ Retirement information including current coverage and dependent information is sent to RHCC.
- ✓ New retirement information is loaded into RHCC's system.
- ✓ Coverage enrollment event complete.
- ✓ Weekly update file sent to carriers following enrollment event.
- ✓ Carrier mails ID cards to retiree within 7-10 days of the date of notification.
- ✓ RHCC sends welcome/notification packet to retirees, which includes the SPD, Health Care Benefits Summary, Benefit Highlights, plan options, etc.
- ✓ Around the 9th of the month prior to the start of Trust coverage, RHCC sends a request to the pension administrator to collect the monthly contribution via pension deduction. This deduction may include retroactive amounts.
- ✓ The pension administrator returns a file to RHCC indicating if a deduction was taken to complete the reconciliation process.
- ✓ RHCC will attempt a pension deduction for up to three (3) consecutive months. If there are sufficient funds, payment will automatically be deducted from the monthly pension going forward.
- ✓ In the event that a deduction cannot be taken, RHCC sends a direct bill (this may include retroactive amounts owed) with an effective date to pay the 1st of the following month and instructions for enrolling in direct debit.

Example Retirement Event

John calls his UAW Benefits Rep to retire on 4/19 (6/ 1 retirement date). The auto company's healthcare administrator sends RHCC the participant's current health care plan information and dependent information on 4/20. RHCC builds the participant data in their system on 4/21. Data files with the retiree's retirement/health care information are sent to the carrier on 4/ 28. The retiree receives their retirement welcome kit during the week of 4/26. Carriers receive enrollment information and process ID cards within 7-10 business days of loading the data into their system. The retiree should have the new ID card by the second week of May, prior to the 6/1 retirement date. If the ID card is not received, the member will need to contact the health plan carrier. The member can obtain the carrier phone number through RHCC or at uawtrust.org/healthplancarriers.

Life Events Impacting Enrollment

Dependents

Eligibility

Dependent spouses and children of retirees on coverage at the time of active coverage will automatically transfer to Trust coverage. Spouses are eligible for coverage for the duration of the marriage to the retiree. Retirees may add children as dependents, but surviving spouses may not. For children to be eligible for Trust coverage they must meet five eligibility requirements:

1. **Relationship:** Children are defined as natural or legally adopted, a stepchild (child of your current spouse), or a child by legal guardianship who is under the age of 18.

2. **Age:** Children may be eligible for coverage until the end of the calendar month in which they reach age 26. They are not subject to this restriction if they are determined to be Permanently and Totally Disabled (PTD) before the end of the calendar month in which they reached age 26.

3. **Marital Status:** Children cannot be married.

4. **Residency:** Children must live with the member, or the member must have legal responsibility for providing health care coverage for the child and the child must reside with the custodial parent.

5. **Dependency:** Children must be dependent on the member, which means they can be claimed as an exemption on the member's federal income tax return unless he or she is responsible for medical coverage due to a divorce decree or Qualified Medical Child Support Order (QMCSO).

Adding Dependents

Only retirees (not surviving spouses or same-sex domestic partners) can add dependents to coverage. Retirees must provide the date of birth and Social Security number for the dependent to RHCC. After the carriers receive the information it takes about 3-5 business days to load the data. Retirees should expect to receive ID cards for the newly added dependent, within 7-10 business days after receipt of the file. If the retiree requests the dependent be added within 30 days following the event (marriage and/or birth or adoption date), coverage will become effective on the date of the event. If the request to add the dependent is more than 30 days

after the date of the event, the effective date will be the first day of the month following the request. The retiree will be required to provide birth certificates and marriage certificates when requested by Dependent Verification Services (DVS).

When a participant is requesting to add a Legal Guardianship or Court Order/QMCSO dependent, paperwork must be received before the dependent can be added. Coverage for dependents meeting these qualifications will be effective the 1st of the month after the receipt and approval of the documentation.

- **Legal Guardianship Dependent:** A copy of the legal guardianship papers (stating full and permanent custody), proof of residency, and the last Federal 1040 filed must be provided. (Income figures may be concealed for privacy and security.)

- **Court Order/QMCSO Dependent:** Participants will be asked to provide a full copy of the court document. Mail documentation to:

  UAW Retiree Medical Benefits Trust
  Attn: QMCSO/ Dependent Eligibility
  P.O. Box 14309, Detroit, MI 48214-9987

The Trust conducts periodic audits to ensure all dependents remain eligible for coverage. During these audits, retirees may be required to provide proof of eligibility for all dependents.

Removing Dependents

It is the responsibility of the retiree to contact RHCC when a dependent(s) becomes ineligible for coverage. Spouses should be removed in the event of a divorce. Dependents who no longer meet the five eligibility tests must be removed. It is the member's responsibility to pay for any fees (claims, monthly contributions, etc.) associated with ineligible dependents.

Dual Coverage

Many retirees have dual coverage under the Trust. For example, a member may be retired from GM and have a spouse retired from Ford or a Chrysler retiree with a GM surviving spouse. Retirees are eligible to maintain dual coverage, but it may not be in their best interest to enroll and pay for coverage for more than one plan. Coordination of Benefits rules do not allow payment to be made from the secondary plan for services more than what would have been paid if the plan was primary.

Medicare Enrollment

All Trust members who are eligible are required to have Medicare Part A to be enrolled in Trust coverage. If a member does not enroll, he or she will no longer be eligible for enrollment in Trust coverage.

The Trust also encourages members to enroll in Medicare Part B when first eligible for three reasons:

1. The Trust will process claims as if a member is enrolled in Medicare Part B regardless if the member chooses to enroll. Enrollment in Medicare Part B will help members avoid higher out-of-pocket expenses. (See example below.)

If a member requires a $2,500 medical service and the Medicare allowed amount for the service is $2,000, Medicare pays 80% of the allowed amount and the Trust pays 20% coinsurance.

Once the member has satisfied the Medicare Part B Deductible, the Trust would pay $400 because Medicare would have paid $1,600, then the claim is considered paid in full.

If a member is eligible for Medicare Part B and chooses not to enroll, the Trust will still pay $400, and Medicare will pay nothing. In this scenario, the balance is the responsibility of the member.

	Enrolled in Medicare Part B	**Not Enrolled in Medicare Part B**
Medical Service Charge	$2,500	$2,500
Medicare Allowed Amount	$2,000	$2,000
Medicare Part B Payment: 80% of Approved Amount	$1,600	$0
Trust Payment (after Medicare Part B deductible and Trust plan out-of-pocket maximum is met)	$400	$400
Member Responsibility:	**$0**	**$2,100**

2. Timely enrollment helps to avoid Medicare penalties for late enrollment. The cost of the Medicare Part B premium increases 10% for each full 12-month period an individual was eligible and did not enroll.

3. Surviving spouses must be enrolled in Medicare Part A and B to continue to be eligible for Trust health care benefits.

Member Communications on Medicare

Trust members will receive up to three letters regarding Medicare enrollment as they approach age 65.

1. **First Letter:** Mailed 90 days before their 65th birthday, which includes information on the importance of Medicare, how to enroll, prescription drug coverage and how enrollment impacts Trust health plan elections.

2. **Second Letter:** Mailed to members who are not enrolled in Medicare during the month of their 65th birthday to ensure they understand the Trust Medicare policy and are aware of the potential higher out-of-pocket health care expenses and possible Medicare premiums penalties they could incur.

3. **Third Letter:** A final reminder mailed to members who are not enrolled in Medicare the month following their 65th birthday reiterating the messages in the second letter.

Special Assistance Program for Medicare

Social Security Disability Insurance (SSDI) & Medicare: The Trust partners with Public Consulting Group (PCG) to assist retirees, surviving spouses and eligible dependents in Social Security Disability and Medicare enrollment, at no cost to the member.

PCG will contact members by sending introductory letters that provide background information on PCG and the potential benefits available. The initial mailing will include a short questionnaire regarding the individual's disability and work history, to be completed and mailed back in a prepaid envelope. PCG is available via phone to ensure members are completely comfortable with the application process.

Public Consulting Group (PCG)
200 Fair Street Ste. 2, Clarkston, WA 99403
888-690-1008 (p) | 888-290-2512 (f)
ssdiuawtrust.com

Members should call Social Security directly for Medicare enrollment at 800-772-1213.

Address Changes

It is important members keep their addresses on file with the Trust up-to-date to ensure they receive updates and other mailings related to their health benefits. Members spending several months away from their primary home can provide RHCC with a temporary address (this does not change their health care plan).

However, a permanent address change may require a change in elected health care plan, as offerings are ZIP Code based. If the member changes a permanent address by calling RHCC, and their current health care plan is no longer available, they will be informed of their plan options and will make an election while on the phone. Plan changes made within the 30 days of an address change are considered Qualified Status Changes and are not subject to rolling enrollment guidelines. Changes made outside of the 30-day period will be processed as part of the rolling enrollment process.

All address changes are effective the 1st of the month following notification. Members must update their address at RHCC at 866-637-7555 for health care purposes. Address changes also must be provided to the pension administrator.

Death Reporting

Following the death of a retiree, dependents will remain on coverage through the end of the month of the death.

If the retiree has a covered spouse, a separate contract under the Trust will be effective the first of the month following the retiree's date of death. Any eligible dependents will be transferred to the new contract. The surviving spouse is required to continue monthly contribution payments.

If the surviving spouse is entitled to a pension benefit and the monthly contributions were taken from the retiree's pension payment prior to death, the monthly contribution will be taken directly from the survivor's pension payment. If the pension amount is insufficient for the monthly contribution or the surviving spouse is not entitled to a pension, he or she may pay monthly contributions through direct debit or monthly invoices from RHCC.

If there is no spouse on coverage but there are other dependents, the dependents will be offered the opportunity to continue health care coverage through COBRA effective the first of the month following the retiree's death.

In the event of the death of a spouse or dependent, health care coverage will terminate effective the date of death.

Transition from Dependent to Surviving Spouse

The following outlines the activities associates with retiree to surviving spouse contract transition:

- Death of the retiree is reported to RHCC.
- Surviving spouse record is built at RHCC.
- A confirmation statement is mailed by RHCC to surviving spouse.
- RHCC will attempt a pension deduction for the monthly contribution. If a pension deduction cannot be taken after three consecutive months, the surviving spouse will receive an invoice (totaling four months) and instructions for enrolling in direct debit.
- The data file will be sent to the health plan carrier following notification of the death.
- Once the health plan carrier receives the file, it will take 3-5 business days to process the data in the system.
- ID cards will be mailed within 7-10 business days of receipt of the file at the carrier.

Available Trust Health Plans

Members should contact RHCC at 866-637-7555 for information on available plan options and to make plan election changes.

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)

The TCN plan is an 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)

The HMO plan is an 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 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

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 within these states have HMO plan offerings available: California, Colorado, Georgia, Maryland, Michigan, Minnesota, Oregon, Washington D.C., Washington (state), and Virginia.

Other Considerations

Below are details on additional considerations impacting Trust plan enrollment.

Rolling Enrollment/Plan Changes

All new retirees transferred to the Trust have the opportunity to make a health care plan change within 30 days if other plan options are available to them. If an election is not made within 30 days, the retiree will be required to use a rolling enrollment process to make a health care plan change.

Rolling enrollment means members will be able to change their benefit election once every 12 months. The 12-month period begins when the new elections have been made. The new plan will be effective the 1st day of the 2nd month following the request. If a new health care plan becomes available, all members in the service area will be given the opportunity to enroll in the new plan overriding the rolling enrollment rules.

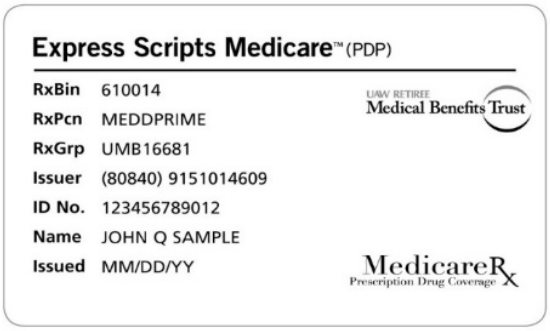
Split Medicare Family

Households consisting of members enrolled in Medicare coverage and others who are not covered by Medicare (known as a "Split Medicare Family") are allowed to split medical plan elections between available non-Medicare and Medicare plan options. This medical plan election flexibility allows Medicare members the opportunity to enroll in Medicare Advantage plans, while non-Medicare members may be enrolled in the TCN plan or an HMO plan, where available.

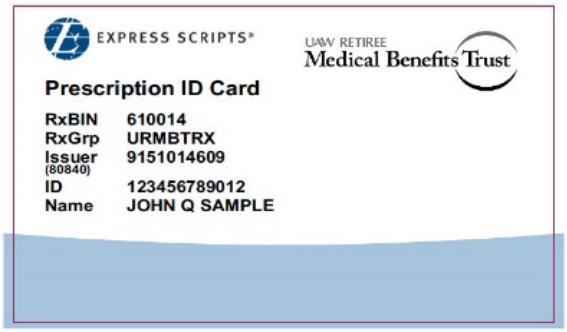
Prescription Drug Benefits

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.

Medications are assigned to one of three categories known as copayment tiers. When a member has a prescription filled, they will typically pay a copayment based on the tier of the medication and how the drug is dispensed (retail pharmacy or mail-order). These amounts are reviewed annually and published in Benefit Highlights.



Medicare-Eligible Members



Non-Medicare-Eligible Members

Mail-Order & First Fills

Members can order prescriptions by mail or have a physician's office place the order via fax or online on their behalf. For medications taken beyond 30 days, members should ask for two copies of the prescription. This allows for a 30-day supply to be obtained from an in-network retail pharmacy and a 90-day supply, plus refills up to one year (if appropriate) to be placed via mail-order. Members should order their refills when they have a two-week supply remaining on their current prescription by contacting Express Scripts Customer Service at 866-662-0274 or at express-scripts.com.

Note: Non-Medicare members must use mail-order for maintenance medications (medications used on an ongoing basis to treat conditions such as high blood pressure or high cholesterol). Those members will be allowed up to three (3) fills at a retail pharmacy. On the fourth fill, the prescription must be filled through Express Scripts Mail-Order to avoid paying the full cost of the drug at retail.

Express Scripts Mail-Order for Medicare Members

If a Medicare member has not had a prescription filled through mail-order in the past 12 months, in order to deliver any new prescriptions that a doctor sends directly to Express Scripts, the member needs to approve the new prescription with Express Scripts. Express Scripts will contact the member through an automated phone message and/or by mail to obtain approval. Once consent is received, the prescription will be processed and mailed. Members do not have to provide consent for each refill. Once the member has authorized Express Scripts to process a renewed prescription, the refills will continue shipping automatically until the prescription expires.

Members can contact Express Scripts Customer Service at 866-622-0274 (Medicare members press one at the prompt) or at express-scripts.com.

Mail-Order Prescription Payments

Once a member accrues charges, Express Scripts will require payment. Members can for pay mail-order charges via check, e-check, money order or credit card. Extended payment options are available by call member services 866-662-0274.

For interested members, there is an automatic payment program. This uses credit card payments and provides uninterrupted service. Members can enroll online at express-scripts.com or by calling 800-948-8779.

Medicare & Prescription Drug Coverage

All Medicare members (except in certain HMO plans) will be automatically enrolled in the group-sponsored Medicare Part D prescription drug plan for Medicare members offered through Express Scripts Medicare™ (PDP). The overall benefit remains similar to the member's non-Medicare prescription drug coverage. For example, the three-tier copay structure, 90-day mail-order program and a requirement of prior authorization for certain medications remains the same.

Medicare rules state that members can only be enrolled in one Medicare Part D prescription drug plan. If a Trust member chooses to enroll in an individual Medicare Part D plan they only can be enrolled in the TCN plan. This will suspend prescription drug coverage provided by the Trust.

Coverage for Medicare Part B Drugs

Certain prescription drugs are covered by Medicare Part B and may be filled at retail or mail-order pharmacy (plan copayments apply). These drugs include:

- Specific medications used to aid tissue acceptance from organ transplants.
- Certain oral medications used to treat cancer.
- Various inhalants used in nebulizers (devices that deliver liquid medication as a mist).

Network retail pharmacies filling Part B prescriptions will work with the member to bill Medicare on their behalf. When using mail-order, Express Scripts will work with its Medicare Part B supplier, Accredo, Express Scripts' specialty pharmacy.

Medicare Part D (Prescription Drug Coverage) – High-Income Individuals

If a member's income as reported on their IRS tax return is above a certain limit, the member may pay an income-related monthly adjustment amount (Part D-IRMAA). Medicare uses the

modified adjusted gross income reported on the IRS tax return from two (2) years ago (the most recent tax return information provided to Social Security by the IRS).

This monthly adjustment, which is updated annually, is paid directly to Medicare and not the Trust. Current amounts can be found on the "Drug Coverage (Part D)" page on medicare.gov.

Medicare "Extra Help"

Extra Help is a Medicare-approved program assisting low-income individuals with Medicare Part D prescription drug copayments. If a member qualifies, the cost-sharing amounts for drugs may be lower than the standard plan benefit. The member will receive a notice called "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Extra Help Rider"), which includes cost details.

The Trust partners with Public Consulting Group, Inc. (PCG) to assist members who may qualify for Extra Help with their Part D prescription drug copayment costs. PCG offers a comprehensive, personalized service, working directly with members on the application. PCG will complete, submit and monitor each application on behalf of the member. The service is free of charge to all members. Information necessary for completing the Extra Help application includes:

- Social Security number.
- Bank account statements, including checking, savings, and certificates of deposit.
- Individual Retirement Accounts (IRA), stocks, bonds, savings bonds, mutual funds, other investment statements.
- Tax returns.
- Payroll slips.
- Most recent Social Security benefits award letters or statements for Railroad Retirement benefits, Veterans benefits, pensions, and annuities.

Members who feel they may qualify for Extra Help can reach out to PCG:
5511 Capital Center Drive, Suite 550, Raleigh, NC 27606
877-522-1061 | extrahelp@pcgus.com

If a member is interested in requesting and completing an Extra Help application themselves, they can:

- Apply online at socialsecurity.gov/extrahelp.
- Apply over the phone by calling 800-772-1213 (TTY 800-325-0778).
- Apply in person at the local Social Security office.
- Apply by mail by calling 800-772-1213 and requesting an application to be mailed to the member. The completed application is then mailed to the Social Security Administration: P.O. Box 1020, Wilkes Barre, PA 18767-9910

Medicare or Social Security will periodically review a member's eligibility to make sure they still qualify for Extra Help. A member's eligibility might change if there is a change in income, resources, marital status or loss of Medicaid.

Low-Cost Generics

Members may use any pharmacy offering lower-cost generics than what is available through Express Scripts. In these cases, members should still provide their Express Scripts ID card, which will check for potential drug interactions with other medications they are currently taking.

Express Scripts also offers more than 400 generic drugs for $10 or less for a 90-day supply. Members can visit www.express-scripts.com/lowcostgenerics or call 877-797-2836 to find out whether a 90-day supply of their generic is available for $10 or less.

Frequently Requested Prescription Drugs Not Covered

Proton Pump Inhibitors (PPIs)

PPI products include: Nexium®, Prevacid®, Protonix®, Prilosec®, Aciphex®, Zegerid®, lansoprazole, pantoprazole, and omeprazole. PPIs are not covered for non-Medicare eligible members. Select PPIs are covered for Medicare-eligible members. To determine if a specific drug is covered, members should reference the Express Scripts Medicare PDP formulary.

A coverage review is available in cases where a member is diagnosed by their physician with Barrett's Esophagus or Zollinger-Ellison Syndrome. To initiate a coverage review, a member or physician must call Express Scripts Member Services at 800-753-2851.

Erectile Dysfunction Drugs

Erectile Dysfunction drugs include: Viagra®, Levitra®, Edex®, Muse®, Caverject®, and Cialis®. Certain strengths of Cialis have a Medicare Part D approved indication and coverage is determined via a prior-authorization process. A coverage review for Viagra only is available in cases where a member is diagnosed by their physician with Pulmonary Arterial Hypertension.

Allergy Serums, Non-Self-Administered Injections, & Insulin/Syringes

Allergy Serums are covered under the medical benefit. All plan covered medications that are non-self-administered injections are covered under the pharmacy benefit. The only exception is applicable non-specialty Chemotherapy IV injections, which are covered under the medical benefit.

In order for syringes to be covered at a $0 copay, injectable medications and syringes must be ordered on the same day as the prescription.

Specialty Medications

Specialty medications are high cost and have a higher risk of discontinuation of therapy. Many of these medications require special handling, storage, monitoring, and consultation requirements compared to other chemical drugs. For these reasons, dispensing 90-days at one time can result in significant waste when discontinuation occurs.

Express Scripts delivers medication without lapses in treatment while limiting member and program costs when a patient cannot tolerate the medication or therapy changes early in the course of treatment.

Why is a 90-day Supply Not Dispensed?

- A plan limit for a specific list of Specialty Medications results in dispensing in smaller day supply increments when obtained through mail-order.
- Over a 90-day period, the member will still receive up to a 90-day supply for the same total current mail-order copay.
- If the order is changed or discontinued, the member saves copay dollars and significant waste is avoided.
- Express Scripts/Accredo actively monitors and initiates/coordinates all refills with patients to ensure they have needed medication and supplies on time.

Appeals

Medical Claim Appeals

If a member has a medical (or dental or hearing) claim that is denied, appeals options are available; however, they must follow the necessary steps in a timely manner.

Step 1: The member must file a first level appeal with the plan carrier within 180 days of receiving the denial and the Explanation of Benefits (EOB) from the carrier. If a member fails to file a first level appeal with the carrier within 180 days, they are not allowed to file a voluntary appeal with the Trust (Step 2).

Step 2: If the appeal is denied by the plan carrier, the member can then file a voluntary appeal with the Trust. More information on this topic is found in the SPD, available at uawtrust.org/documents.

Prescription Drug Pharmacy Appeals

Appeal claim submissions are due within 12 months of the date of service. Claims received after this period will be denied unless the member can show it was not possible to provide notice within the required time and the claim was filed as soon as reasonably possible.

Express Scripts Appeals for Non-Medicare Members

Administrative reviews and appeals are based on the plan's benefit design or conditions of coverage without additional information required from the prescriber.

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587, St. Louis, MO 63166-6587

Clinical reviews and appeals are based on conditions of coverage and may require additional information from the prescriber.

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588, St. Louis, MO 63166-6588

- Initial Determination Coverage Review reviewed by Express Scripts
  - Member calls Express Scripts at 800-753-2851 to initiate the review
- Initial Administrative Determination Coverage Review reviewed by Express Scripts
  - Member calls Express Scripts customer service at 866-662-0274 and a coverage review form is sent to the member

    - For urgent administrative review, members should call Express Scripts at 800-946-3979
- Level 1 Appeal reviewed by Express Scripts
- Level 2 Appeal reviewed by Express Scripts

Members must exhaust all levels of the appeal process at Express Scripts before submitting a voluntary appeal to the Trust.

UAW Retiree Medical Benefits Trust
Attn: Appeals
P.O. Box 14309, Detroit, MI 48214-0309

Prescription Drug Copay Review: Non-Medicare Members Only

A copay review is available to Trust members. If approved, the copay for a brand-name medication falls under the Tier 2 copay amount. (Based off of FDA MedWatch form that the member's doctor must submit.) To initiate a copay review, a member should call Express Scripts at 800-841-5409.

Express Scripts Appeals for Medicare Members

Clinical reviews are similar for the Express Scripts Medicare PDP. However, if a member's Level 1 Appeal is denied, and the member decides to proceed with a Level 2 Appeal, the Independent Review Organization reviews the decision. The Independent Review Organization is an independent organization that is hired by Medicare. Reviewers at the Independent Review Organization will take a careful look at all of the information related to the appeal. The organization will tell the member its decision in writing and explain the reasons for it.

If the dollar value of the drug the member has appealed meets certain minimum levels, the member may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, the member cannot appeal any further.

For a complete listing of the appeal process for the Express Scripts Medicare PDP, review Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints) in the Evidence of Coverage for Express Scripts Medicare document.

Trust Appeal Process

If a medical or prescription drug claim is denied in whole or part, members have the right to file an appeal with the Trust. If the claim remains denied during the appeal process at the carrier, the member may request a voluntary Trust review. Detailed information can be found in the SPD. If you assist a retiree in filing an appeal, the Personal Health Information (PHI) Authorization Form is required. Copies of the form are available online at uawtrust.org/UBRFileCabinet. The appeal and PHI form should be mailed to the Trust address above.

Prescription Drug Prior Authorizations

For a medication requiring a prior authorization, the member or prescriber can call Express Scripts at 800-753-2851.

Additional Plan Provisions

Advance 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.

Resources

There are several resources available to assist with member inquiries.

UAW RETIREE MEDICAL BENEFITS TRUST | uawtrust.org

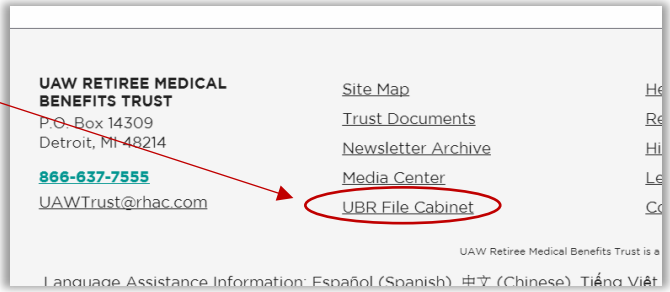
In addition to providing a deeper history of the Trust (its mission, biographies of the Board of Trustees, etc.), the Trust's website also includes detailed information on:

- Medical Benefits
- Prescription Drug Coverage
- Medicare Information
- Eligibility
- Resources, website links, and answers to common questions
- Videos on benefits and other topics
- Mailed communications archive

On the Documents page of the website, you can download important documents:

- **Summary Plan Description (SPD):** Complete detail of what the plan provides and how it operates. (Updated and mailed to all members every five years)
- **Benefit Highlights:** Annual statement of updates to plans and cost share information. (Fall)
- **Health Care Benefits Summary:** Summary of plan and cost changes since the previous issue of the SPD. (Provided to new Trust members only)
- **Summary Annual Report (SAR):** Department of Labor-required summary of the Trust's financial status. (Fall)

UBR File Cabinet: Access updated information and resources (click on the link in the footer of the website).



We encourage UAW locals and regions to link directly to our homepage on their websites. Please refrain from reposting documents or including links to individual documents. Document names and pages may change throughout the year causing referring links to become broken.

Escalation of Member Issues

To escalate a member issue to the Trust, download and complete the Member Inquiry Form found on the UBR File Cabinet (under the "UBR References" column) and submit the form to memberexperience@rhac.com.

RETIREE HEALTH CARE CONNECT (RHCC)

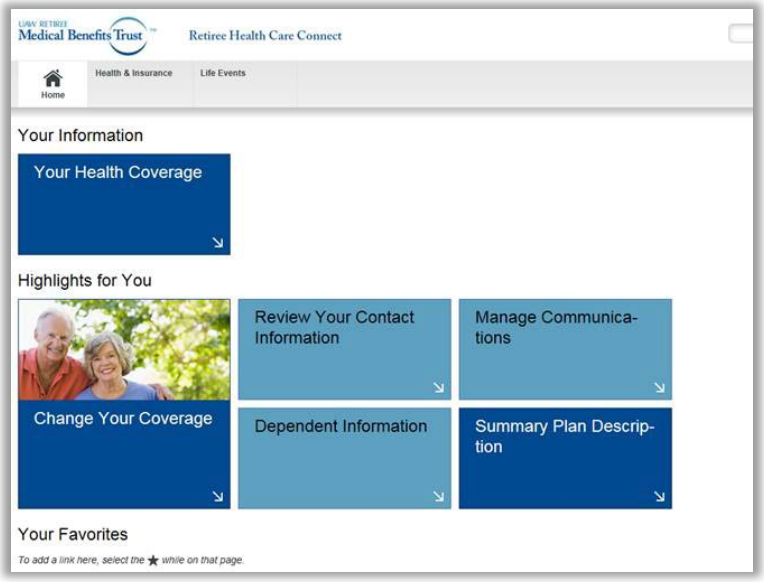
866-637-7555
http://digital.alight.com/rhcc/

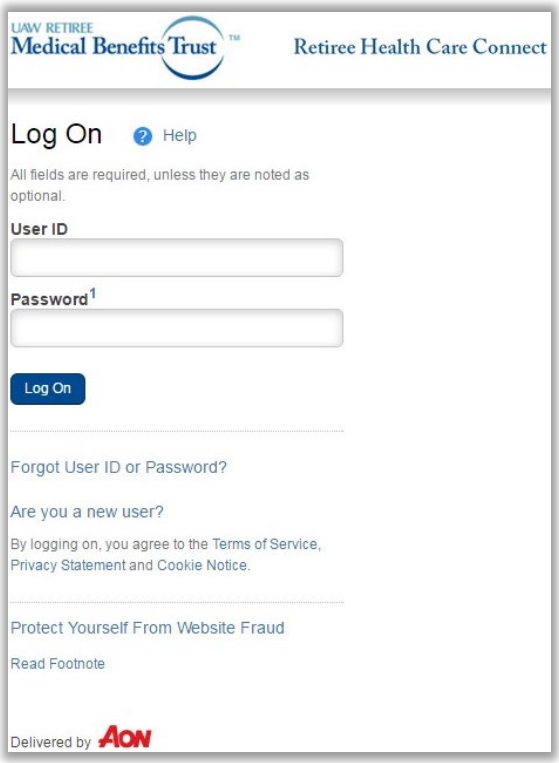
When members first log onto the website, they will need to register by creating a unique User ID and password. To register, members will need the last four digits of their Social Security number, birth date, and ZIP Code.

If a UBR is transacting for a member – you MUST log on as the member and will need to complete the registration, if necessary.

Once logged on, members have access to several functions:

- Physical address change
- Add an email address
- Add a phone number
- Qualified Status Changes (reporting dependent changes, death, etc.)
- Change banking information
- Heath care plan modeling
- Request forms
- Payroll deduction/direct billing information





Contact information

NOTE CONTACTS IN RED: FOR UBRS ONLY (NOT FOR MEMBER USE)	
AUTO RETIREMENT	
GM: FIDELITY	800-489-4646
FORD: ACS	800-248-4444
CHRYSLER: BENEFITS CONNECT	888-409-3300
UAW TRUST	
RETIREE HEALTH CARE CONNECT (RHCC) UBR HOTLINE	866-617-2216
MEMBER EXPERIENCE (UBR CONTACT FOR ALL AUTOS)	memberexperience@rhac.com Fax: 313-324-5950
PLAN CARRIERS	
AETNA UBR CONTACTS	Pam Killebrew, Region 2B 860-900-5962 Angela Plante, Region 4 860-900-5964 Brian Perkins, Region 5 959-299-5290 Kaketta Mills, Region 8 860-900-5967 Diane Peers, Region 9 860-900-5971 Michael Young, Region 9A 860-900-5969
BLUE CROSS BLUE SHIELD TCN & MA PPO ONLY UBR LINE	800-348-6559
BLUE CROSS BLUE SHIELD ECP	Health Guide: 866-507-2850
EXPRESS SCRIPTS (RX) UBR CONTACT	Matt Hammons (513) 502-7156 jmhammons@express-scripts.com
DELTA DENTAL: GM UBR LINE	866-696-7439
DELTA DENTAL: FORD UBR LINE	800-656-6496
DELTA DENTAL: CHRYSLER UBR LINE	855-274-0888
OTHER	
PUBLIC CONSULTING GROUP (PCG) SOCIAL SECURITY DISABILITY INSURANCE (SSDI)	https://www.ssdiuawtrust.com/ 888-690-1008
PUBLIC CONSULTING GROUP (PCG) – EXTRA HELP FOR MEDICARE PART D PRESCRIPTION DRUGS	877-522-1060 extrahelp@pcgus.com extrahelpuawtrust.com
For member-facing and other available contact information/resources, visit: uawtrust.org/healthplancarriers.	