

“MY LIFE
MY TRUST
MY BENEFITS”

QUICK REFERENCE GUIDE



WELCOME

UAW RETIREE MEDICAL
BENEFITS TRUST MEMBER



WELCOME TO THE UAW RETIREE MEDICAL BENEFITS TRUST



The UAW Retiree Medical Benefits Trust, or simply the “Trust,” administers your health care benefits as an eligible retired General Motors, Ford or Chrysler UAW member.

WHAT EXACTLY IS THE TRUST?

The Trust is a Voluntary Employees’ Benefit Association (**VEBA**). It is a trust fund that holds and manages assets to provide health care benefits for UAW retirees from General Motors, Ford and Chrysler. In 2010, the Trust was the largest non-governmental purchaser of retiree health care in the United States.

As a Trust participant, we welcome you to your health care benefits. Before we dive into explaining the “what,” “how,” and “why” of your benefits, we want you to know that we understand how complicated health care can be. It’s easy to get lost in the “alphabet soup” of acronyms and terms, not to mention all of the options available out there. Our mission is to help you understand your health care options so you can enroll in a plan that works for you and your family.

As you enter a new chapter in your life, we created this booklet with the intent of providing you a foundation to better understand your medical benefits and how to get the most out of them. These days, it’s more important than ever to be informed about your health care so you can make the best choices for you and your family.



Terms **bolded** throughout this book are defined in the glossary.

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Note: This document is not and should not be considered a “plan document” as defined by the Employee Retirement Income Security Act (ERISA). Participants should rely on their Summary Plan Descriptions (SPD) and Plan Documents for benefit descriptions.

Visit us online: www.uawtrust.org

HISTORY: ABOUT THE TRUST



To understand how we got where we are today, let's first go over some background information on the Trust.

Before the Trust was established, the UAW bargained with General Motors, Ford and Chrysler for retiree health care benefits as part of contract negotiations. So, what happened?

Costs increased throughout the years and it became difficult to manage. To avoid losing the benefits completely, which would have been possible (they're not legally protected like pension benefits), the UAW bargained with the autos to establish a separate Trust to manage and protect the retiree health care benefit offerings.

2010: A TRUST IS BORN

Once it was agreed that retiree health care benefits would be managed and administered by the new Trust, each auto provided a one-time set amount of money with no commitment to provide further funds. In 2010, the Trust began the management of the funds within each individual auto company bucket, both in terms of investments (growing the funds for the future) and benefit design and administration.

UAW TRUST FUNDS

FORD

GM

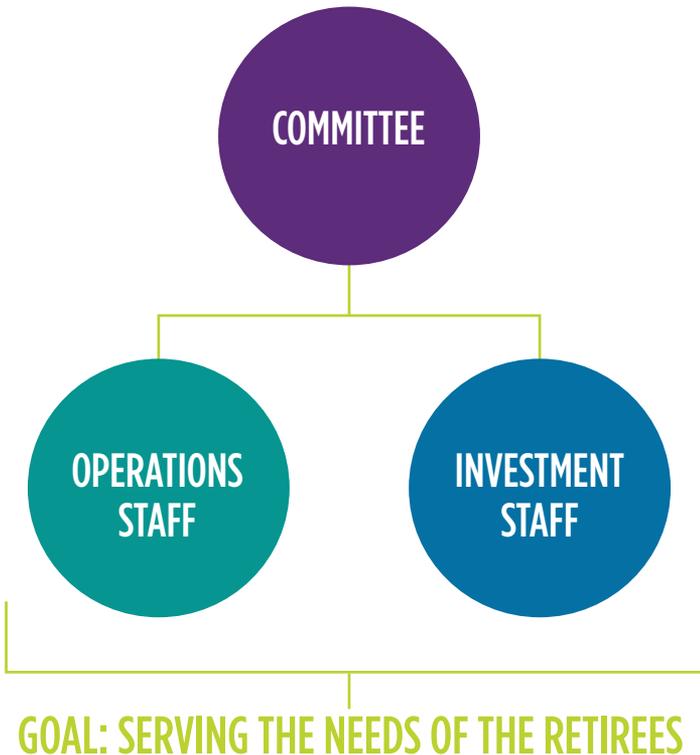
CHRYSLER

For instance, a Ford retiree's benefits are paid only out of the Ford bucket of funds. Because there is no new money from the auto companies coming in, the Trust is made up of not only operations staff, but a highly-motivated investment staff who works hard to make sure the Trust stays funded and able to provide you and your eligible dependents with a comprehensive set of benefits.

CHECKS & BALANCES

To make sure everything is running as it should, both in terms of investments and benefits offered, the Trust is governed by an 11-member board of trustees (the committee).

For more background information on the History, Structure and Funding of the Trust, you can access a detailed video at www.uawtrust.org.





ELIGIBILITY FOR UAW RETIREES

Now that we have looked back at the history of the Trust, let's look at who our health care is offered to – retired General Motors, Ford and Chrysler UAW members.

The Trust's membership is a closed group and the benefits are only available to people who either:

- Were retired from a UAW-represented position when the Trust was first bargained in the fall of 2007
- Were actively employed in a UAW-represented position and had attained seniority by the fall of 2007

Retirees are also called the primary enrollee. They are eligible for Trust health coverage based on the terms of retirement from their auto company.

WHAT ABOUT EVERYONE ELSE?

YOUR SPOUSE

The **spouse** of a retiree may be eligible for coverage for the duration of the marriage.

- If the retiree divorces his/her **spouse**, the **spouse** will no longer be eligible for Trust coverage.
- If the retiree re-marries, the new **spouse** may be eligible for Trust coverage.

SURVIVING SPOUSES

In the event of the passing of the retiree, the **spouse**, known as the **surviving spouse**, will remain eligible for Trust health coverage, and become the primary enrollee. In this event the surviving spouse must:

- Either be (1) enrolled on the date of the retiree's death or (2) enrolled in the active auto company plan and the active employee was eligible to retire on the date of death.
- Be enrolled in **Medicare Parts A and B**, once eligible.
- Pay any required **monthly contribution** (more on this later).



DEPENDENT CHILDREN

Dependent children are eligible for coverage as well. Children are eligible for coverage if they meet all of the following five requirements:

- 1. Relationship** – Children are defined as a natural or legally adopted child, stepchild (child of the retiree’s current **spouse**), a child placed with you for legal adoption who is under age 18 or a child by legal guardianship.
- 2. Age** – Children may be eligible 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 prior to the end of the calendar month in which they reached age 26.
- 3. Marital Status** – Children must not be married.
- 4. Residency** – Children must live with the primary enrollee as a member of the household or the primary enrollee must have legal responsibility for providing health care coverage for the child, and the child must reside with the custodial parent. Children still meet residency requirements if they live away from enrollee as a result of attending an institution of higher learning as a student or if they (or the enrollee) live in a group home or other health care facility.
- 5. Dependency** – Children must be dependent on the primary enrollee, which means the primary enrollee can claim an exemption on his/her federal income tax return unless the primary enrollee is responsible for the dependent’s medical coverage due to a divorce decree or Qualified Medical Child Support Order.

Retirees may add children as dependents, but surviving spouses may not.

ELIGIBILITY AUDITING

Periodically, we will request that you validate the eligibility of the dependents covered under your health plan. This process is called an audit and will require you to provide documentation such as birth certificates, death certificates, tax return copies and/or marriage certificates. **You'll want to make sure you respond to all requests for documentation;** if you ignore this request your dependent(s) may lose coverage. If that happens, we can work with you to get the necessary information and get the coverage active again, but it's always easier to avoid a gap in coverage, if possible.

If your dependent becomes ineligible for coverage, by not meeting one or more of the criteria, you must call Retiree Health Care Connect (RHCC) at 866-637-7555 immediately to drop them from coverage. Failure to drop an ineligible dependent may result in financial responsibility for you – equal to all health care costs associated with the ineligible dependent inappropriately paid by the Trust.



ENROLLMENT

Included in this package is an “Enrollment Worksheet.” That statement confirms your medical coverage and the date it becomes effective.

The Enrollment Worksheet lists all health care plan options available in your service area. If you wish to remain in the plan assigned on the sheet, no action is required by you. If you want to choose another health care plan available in your area, as shown on the statement, you will need to contact RHCC at 866-637-7555. You will receive a welcome kit and medical ID cards directly from your health care plan.

In addition, you’ll want to verify the eligibility of any dependents listed on the statement, based on the guidelines discussed earlier in this booklet.

MONTHLY CONTRIBUTION

You may be required to pay a **monthly contribution** to the Trust.

Your contribution helps cover enrollment costs and plays an important role in our ability to continue benefit offerings.

The amount may vary depending on enrollment factors such as family size or enrollment option – for current contribution amounts see the enclosed “Health Care Benefits Summary” document. **Monthly contributions** are typically made through a pension deduction. However, if you are eligible for coverage but not receiving a pension, or are unable to pay from your pension, you may make payments through direct debit or pay a monthly invoice.

WHAT TO EXPECT

WHAT SHOULD I EXPECT?

This book comes to you as part of a larger “welcome packet.” In this packet, you also received a Summary Plan Description (SPD) which includes complete details on all of the topics covered in this booklet. The SPD is also available to download online at www.uawtrust.org.

You will receive materials from the Trust throughout the year on your benefits, as well as helpful resources to make you a better health care consumer. Always open any mail with the Trust logo on it:



WHAT TO EXPECT



This graphic is designed to show you key pieces of information that you will receive throughout the year so you'll know (for the most part) what to expect from the Trust:

**January -
February**



Notice of Minimum Essential Coverage (for non-Medicare members):
IRS-required notification that your Trust medical coverage meets minimum requirements.

**July -
September**



Age 19-26 Dependent Audit (members with Dependent Children aged 19-26):
Verification of dependent eligibility under Plan rules.

**September -
October**



Benefit Highlights:
Annual statement of updates to the plans and cost share information.

**November -
December**



Status of Trust and Summary Annual Report:
Department of Labor required summary of the Trust's financial status.

Other



Age-in to Medicare Letter (for members turning 65 years old): Three letters are possible – the first will come 90 days before your birthday; the second the month of your birthday, if you’ve not yet enrolled in Medicare; and the last in the month after your birthday, if you’ve not yet enrolled in Medicare. Also, you will receive a “Welcome to Medicare” kit from Medicare, as well as letters from carriers about your new plan options.

What we send you is important. In order to stay informed, the most important thing you can do is to make sure we have your correct telephone number, address, and email information on file.

How do you do that? Call us:

Retiree Health Care Connect (RHCC) 866-637-7555

RHCC is your one-stop-shop to connecting with the Trust.

One phone call can help you:

- Get information on enrollment and disenrollment (i.e. how do I enroll my child?)
- Get information on eligibility (i.e. is my child eligible after age 18?, what happens in a divorce?)
- Learn what alternative health plan options are available.
- Update your telephone number, address information, and email address on file.
- Report life-changing events (i.e. death, marriage, etc.)



Let's take a closer look at your Trust health care coverage. First, it's important to understand that the plan options available to you depend on where you live and can vary based on your **Medicare** eligibility. Also, you need to keep in mind that plan options are reviewed annually and often times there are yearly changes that will be communicated to you in the "Benefit Highlights" document you'll receive every fall.

Now, let's discuss some basic similarities of our plan options. All Trust provided plans have **copay** elements and cost share elements.

- **Copay elements** are fixed dollar amounts for services such as primary care physician (PCP) office visits, specialist visits, **urgent care** visits and emergency room visits.
- **Cost share elements** can include **deductibles**, **coinsurance** and **out-of-pocket maximums**.

Copays do not go toward the cost share elements for ECP, TCN and MA PPO plans. Things that go toward cost share elements include: lab tests, surgeries, body scans, etc.

MEDICARE ADVANTAGE (MA) PPO

Medicare Advantage PPO plans, referred to as **MA PPO** plans, are the primary plan for **Medicare** Trust members. They are approved by **Medicare** and administered by private companies. They provide all of your Original **Medicare Part A** (hospital) and **Part B** (medical) benefits, and include some additional benefits, too. **MA PPO** plans have provider networks, so in order to receive the highest level of benefits with the lowest out-of-pocket cost, you need to receive services from **in-network** providers.

- **Who is eligible?**

Members enrolled in **Medicare Parts A and B**. To stay eligible for these plans, you must continue to pay your monthly **Medicare Part B** premium. Most **Medicare**-enrolled Trust members are automatically enrolled in the **MA PPO** plan on January 1, following the year they qualify for **Medicare**.

- **Copay elements?**

These plans may have **copays** for primary care physician (PCP) office visits, specialist visits, **urgent care** visits and emergency room visits.

- **Cost share elements?**

These plans have **deductibles**, **coinsurance** and **out-of-pocket maximums**.



TRADITIONAL CARE NETWORK (TCN)

The **Traditional Care Network** plan, referred to as the **TCN** plan, is the base plan option available to **Medicare** members. For **Medicare** members in this plan, **Medicare** is primary and **TCN** coverage is secondary. This plan is based on a nationwide network of providers and allows services to be performed both **in-network** and **out-of-network**.

- **Who is eligible?**

Medicare Trust members.

- **Copay elements?**

This plan may have **copays** for **urgent care** visits and emergency room visits.

- **Cost share elements?**

This plan may have **deductibles**, **coinsurance** and **out-of-pocket maximums**.

ENHANCED CARE PPO (ECP)

The **Enhanced Care PPO** plan, referred to as the **ECP** plan, is the primary plan for all non-Medicare Trust members. This plan is based on a nationwide network of providers and allows services to be performed both **in-network** and **out-of-network**.

- **Who is eligible?**

All non-Medicare Trust members.

- **Copay elements?**

This plan may have **copays** for primary care physician (PCP) and specialist office visits, **urgent care** visits and emergency room visits.

- **Cost share elements?**

This plan may have **deductibles**, **coinsurance** and **out-of-pocket maximums**.

These are the main plan options available to the majority of our members. However, in some areas, there are other plan options available. Be sure to review the “Enrollment Worksheet” included in this package for all of the plan options available to you. For more information on additional plan options, reference the SPD booklet or call RHCC at 866-637-7555.

SO, HOW DOES “COST SHARE” WORK?

When both you and your health plan pay part of your medical expenses, it’s called cost-sharing. As we’ve discussed throughout this book, **deductibles**, **coinsurance** and **out-of-pocket maximums** are all examples. Understanding how they work will help you know when they apply and how much you will have to pay for care.

COPAY

A **copay** is a fixed dollar amount for a covered service, usually paid when you receive the service. The amount can vary by the type of service. Examples of **copay** services include primary care physician and specialist office visits, **urgent care** and emergency room visits. Prescription drugs also have a **copay** when filled. **Copays** are separate from other cost-sharing elements and generally do not count toward your **deductible** and **out-of-pocket maximums**.

DEDUCTIBLE

A **deductible** is the amount you pay for health care services before the plan begins to pay. Let’s say your plan’s **deductible**

PLAN OPTIONS



is \$500. That means for most services, you'll pay 100% of your medical bills, until the amount you have paid reaches \$500. Remember, **copay** services do not count toward your **deductible**. After that, you share the cost with your plan by paying **coinsurance**.

COINSURANCE

Coinsurance is your share of the costs of a health care service. In the case of our plans, it's figured as a percentage of the amount. You start paying **coinsurance** after you've paid your **deductible**.

OUT-OF-POCKET MAXIMUM

The **out-of-pocket maximum** is the most you will have to pay for covered medical expenses in a plan year through **deductible** and **coinsurance** before the health plan begins to pay 100% of covered medical expenses. Remember, **copay** services generally do not count toward the **out-of-pocket maximum** and do not stop when that maximum is reached.

Here's how it works. Jeff has been experiencing knee pain and his doctor ordered an MRI, which costs \$750. He had already reached his **deductible** of \$500. So in this example, the plan covers 90% of the cost of the MRI. Jeff is responsible to pay the other 10%; that's his **coinsurance**. For this service, the plan pays \$675 and Jeff pays \$75. Jeff continues to pay 10%, his **coinsurance**, on services until he reaches the **out-of-pocket maximum**. Once he has reached the **out-of-pocket maximum**, the plan then pays 100% of the costs.

Deductible and out-of-pocket maximum amounts used for illustrative purposes only. Please see the "Health Care Benefits Summary" for actual amount of deductible for your plan.



**JEFF PAYS
100%**



**TRUST PAYS
0%**

Jeff needs an X-ray. He hasn't reached his \$500 deductible.

Copay services like doctor visits, urgent care, ER visits and prescription drugs do not count toward Jeff's deductible.

X-ray cost: \$125

Jeff pays **\$125** • Trust pays **\$0**



**JEFF PAYS
10%**



**TRUST PAYS
90%**

Jeff reaches his \$500 deductible – Coinsurance begins.

Jeff has had several covered medical services and procedures paying \$500 in total. His plan pays some of the costs for his next service:

MRI cost: \$750

Jeff pays 10% of \$750 = **\$75**

Trust pays 90% of \$750 = **\$675**



**JEFF PAYS
0%**



**TRUST PAYS
100%**

Jeff reaches his \$1,000 out-of-pocket limit.

Jeff has had many covered medical services and procedures paying \$1,000 in total – not including copay services. The Trust will now pay the full cost of his covered health care services (excluding copay services) for the rest of the year.

Lab services: \$150

Jeff pays **\$0** • Trust pays **\$150**



Whether you're in good health or taking steps to manage a condition, knowledge is essential in preventing complications and staying well. When you are actively engaged in your health care, you can live a longer, higher-quality life. Since the Trust's launch, our members have worked closely with us to maintain good health and keep costs for services and prescription drugs affordable.

HOW DO YOU GET INVOLVED?

There is no better time to take charge of your health. The best place to start is by understanding your health care benefits and learning more about your health.

HEALTH INFORMATION

In addition to the benefit-related information we send you throughout the year, we will also send you health-related information. There's a lot of health-related information out there, which makes it difficult to know what's the most accurate and relevant to you. We've collaborated with a variety of recognized organizations to offer you and your family new health care resources and information. From understanding recommended tests for your age and gender to complicated issues like knowing how to navigate through the health care system, the resources we will share can help you have better conversations with your doctors, which in turn can lead to better health.

REMINDERS: IMMUNIZATIONS, SCREENINGS & OFFICE VISITS

To help you stay on track, throughout the year you will receive helpful reminders to utilize your benefits for things like immunizations (i.e. flu shots), preventive screenings and primary care physician office visits. Typically, these will come in the form of postcards, letters and possibly even a reminder phone call.

IMMUNIZATIONS

Many adults are not aware of vaccines recommended for them – and that means they are not taking advantage of the best protection available against a number of serious diseases. As we get older, illnesses such as flu, pneumonia and shingles become especially concerning, particularly for people with a chronic conditions such as heart disease, diabetes, or chronic lung disease.

Luckily, vaccines for these illnesses are a part of your Trust benefits. It's important to stay up-to-date on your immunizations because no one can predict when exposure to preventable diseases will occur, and no one wants to feel sick. The best way to protect yourself and your family is to talk to your doctor about which vaccines you need and how often you should receive them.



SCREENINGS & OFFICE VISITS

If you haven't visited a primary care physician (PCP), you may receive a reminder to do so. Regularly visiting a PCP is important for your health and wellness. As a Trust member, your benefits include PCP office visit coverage (because each plan is different, find out exactly what your plan covers before you schedule an appointment).

We encourage you to use this benefit to establish a relationship with a physician with whom you feel comfortable discussing your health history with and working together to maintain your health. PCPs are responsible for preventive health, detecting diseases early or preventing them in the first place, for treatment of minor illnesses and managing chronic disease like high blood pressure, diabetes and COPD. These doctors make sure you're getting necessary screenings (such as retinal exams for diabetics) and have a complete picture of your health. A PCP should be your first point of contact to prevent and manage chronic diseases.

We want to help you take an active role in your health care by providing you with the right information. To learn more, visit us online at www.uawtrust.org – the "Health and Wellness" section is dedicated to providing information you can use when learning about a condition or to help you prepare for a visit with your doctor.



We know that prescription drugs are an important part of maintaining health and managing disease. Your prescription drug coverage through the Trust applies to prescriptions filled at retail pharmacies and through a mail-order program.

HOW DO PRESCRIPTION COPAYS WORK?

Medications are assigned to one of three categories known as **copayment** tiers. When you have a prescription filled, you will typically pay a **copayment** based on the tier of that medication.

TIER 1 Generic drugs
TIER 2 Preferred brand-name drugs and some select generics
TIER 3 Non-preferred brand-name drugs

Medications in the Tier 3 category are drugs in which lower-cost alternatives are available among the Tier 1 or Tier 2 category. These medications have the highest **copayment** amount.



If the cost of the drug is less than your **copayment**, you will only pay the cost of the drug. Your prescription drug **copayment** amount for each prescription order or refill will be determined based on whether the drug is **generic** or brand name, the applicable “tier” of the drug, and how the drug is dispensed (retail pharmacy or mail-order). These **copayments** are established annually and can be found in the “Health Care Benefits Summary.”

MAIL-ORDER PROGRAM

As part of the Trust’s prescription drug coverage, there is an easier, more convenient and cost-effective way to get your ongoing prescription medications through the mail-order option. By using mail-order, you will have your prescriptions delivered right to your home – plus shipping is free to you. In most cases, you can order up to 90-days of prescription drugs at once. Non-Medicare members must use mail-order for maintenance medications (i.e. those you use on an ongoing basis to treat conditions such as high blood pressure or high cholesterol).

GENERIC VS. BRAND-NAME

If you’ve had a prescription filled recently, there’s a good chance you’re taking a **generic drug**. Almost 80% of all prescription drug sales are generics. Their use helps save patients and hospitals billions of dollars every year.

According to the U.S. Food and Drug Administration (FDA), **generic drugs** can be trusted to have the same quality as brand-name drugs – but at a cheaper price. That’s important to know because no one wants to skimp on health, even if it means saving money.

The FDA requires a **generic drug** to meet standards that make sure it's the same basic product as the brand-name drug. That means the **generic drug** is safe and can be taken:

- The same way as a brand-name drug.
- For the same reason as a brand-name drug.

Generic use at the Trust has increased from 68% in 2010 to 88% in 2015. This increase in use has helped the Trust avoid unnecessary increases to prescription drug copays.

WHY ARE GENERIC DRUGS IMPORTANT?

Creating drugs costs a lot of money. Since **generic drug** makers do not develop a drug from scratch, the costs to bring the drug to market are less. But, remember they must show that their product performs in the same way as the brand-name drug. All **generic drugs** are approved by the FDA.

PRESCRIPTION DRUG ID CARDS

Most members will receive a separate ID card for prescription drug coverage from Express Scripts. You will need to present this ID card when receiving prescription drugs through the retail pharmacy. However, for some plans, you will not receive a separate prescription drug ID card. You will continue to show your medical ID card when receiving prescription drugs through the retail pharmacy.

You will likely receive a new prescription drug ID card when you become **Medicare**-enrolled, as the Trust will automatically enroll you in its **Medicare Part D** plan through Express Scripts. The overall benefit will remain similar to your previous prescription drug coverage. For example, the three-tier **copay** structure, 90-day mail-order program and a requirement of prior authorization for certain medications will remain the same.



YOU'RE COVERED FOR EMERGENCIES WORLDWIDE

You can receive **emergency** health care services when you're away from home. Always carry your medical ID card with you and show it when obtaining services.

TRAVEL & MEDICARE

In most cases, **Medicare** does not cover services outside the United States and directs travelers to research travel insurance policies for more coverage. An insurance agent or travel agent can give you more information about buying travel insurance. Travel insurance doesn't necessarily include health coverage, so it's important consult your travel or insurance agent on the conditions or restrictions.

For more information on travel and your health care benefits, call the number on the back of your medical ID card.



Here you'll find answers to some of the questions we get most frequently.

ELIGIBILITY

1. What if I have coverage with another health care plan (i.e., through my **spouse**) and decide to waive this coverage now – can I come back later?

Yes. If you are an eligible retiree or surviving spouse covered under another plan you can enroll in Trust coverage in the future.

2. My **spouse** and I both are UAW retirees – can we cover one another?

Yes. If you each retired from different auto companies, you can choose to carry your own coverage individually or you can each cover the other as a dependent. However, if you decide to cover each other, you will both be responsible for separate monthly family contribution rates. Note, in most cases, there is no advantage to having dual coverage as the coordination of benefits rules do apply.

DEPENDENTS

1. Can I cover my **spouse**?

Yes. Your **spouse** (same-sex or opposite-sex) is eligible for coverage at the time of your retirement. If you get married or re-married after retirement, your new **spouse** will be eligible for coverage. Surviving spouses cannot add new **spouse** to coverage.



2. As a retiree, can I cover my children?

Yes. Trust retirees can add dependents to coverage. They remain eligible until the end of the month they turn 26 years of age. However, they must be unmarried, reside with you, and be legally claimed as an exemption for federal tax purposes, unless you are responsible for their medical coverage due to a divorce decree or Qualified Medical Child Support Order.

3. As a surviving spouse, can I add dependents?

Surviving spouses cannot add new dependents to coverage. Any dependents on the health care contract prior to the retiree's death will continue to be covered until they no longer meet the eligibility rules.

4. Does the Trust audit dependent status?

Yes. The Trust has a responsibility to make sure all covered retirees and dependents are eligible.

5. Is my grandchild eligible for Trust coverage?

No. The Trust covers natural born children and adopted children through the month of his or her 26th birthday, and children for which you have legal guardianship through the age of 18.

6. Does the Trust require that my dependents be students in order to be covered?

No.

7. Will my married dependent child transfer to the Trust when I retire?

No. Married **dependent children** are not eligible for coverage at the Trust.

8. Can I continue coverage when my child reaches age 26?

No. **Dependent children** coverage does not extend beyond 26 years of age. Prior to the end of the month of your child's 26th birthday, a COBRA package will be mailed to your address and you can elect COBRA coverage for your child at that time.

9. If my child is Permanently and Totally Disabled (PTD) can I continue their coverage beyond age 26?

Yes. If your child is Permanently and Totally Disabled (PTD), coverage may be continued beyond age 26.

HEALTH PLANS

1. Will my health care coverage be the same in retirement as when I was an active worker?

No. You may have the same health care carrier as you did as an active employee. However, the covered benefits and cost-share will differ. Be sure to review your "Enrollment Worksheet" statement for your assigned plan and any other plan options available to you.

2. Who should I contact with a claim issue?

You should call your health care plan carrier at the member service phone number on the back of your ID card.



3. Can I change my health care plan?

Yes. If other plans are available in your area, you will have 30 days from the date you retire to change your health care plan effective with your date of retirement. After that initial 30 days, you will be subject to the **rolling enrollment** rules. **Rolling enrollment** means you will be able to change your benefit elections 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 your request.

4. Who do I contact to change to a different health care plan?

To change your health care plan, you will need to contact RHCC at <http://digital.alight.com/rhcc> or call 866-637-7555 between 8:30 a.m. and 4:30 p.m. Eastern Time. If you are **Medicare** enrolled, you cannot enroll online; you must call RHCC to change plans.

MEDICAL ID CARDS

1. What should I do with the medical ID card I have from my coverage as an active worker?

You should use your current ID card until your retirement date. After retirement, you will receive a new medical card for your coverage under the Trust. You will want to use that card after your retirement date.

2. When will I receive my new ID card?

You should receive your ID card within 2 weeks of your effective date of retirement.

3. Who should I call if I do not receive my new medical ID card?

You should contact RHCC at 866-637-7555 between 8:30 a.m. and 4:30 p.m. Eastern Time.

PRESCRIPTIONS

1. Will I have a separate ID card for prescription drug coverage?

Yes. You will receive a separate ID card for prescription drugs from Express Scripts. You will need to present this ID card when receiving prescription drugs through the retail pharmacy.

For some plans, you will not receive a separate prescription drug ID card. You will continue to show your medical ID card when receiving prescription drugs through the retail pharmacy.

2. Is there a mail-order prescription program?

Yes. In fact, it's the easier, more convenient and cost-effective way to get your ongoing prescription medications. By using mail-order, you will have your prescriptions delivered right to your home with no shipping fees. If you are a non-Medicare member and on a maintenance drug, those that are taken on an ongoing basis (three months or more) to treat conditions such as high blood pressure or high cholesterol, you are allowed three fills at the retail pharmacy. After the third fill, you will be required to use the mail-order program or be responsible for the full cost of the prescription drug.

3. What are the benefits of using the mail-order program?

Mail-order provides the convenience of home delivery, as well as a cost savings compared to the retail pharmacy – you can get a 90-day supply through mail order for only two times the **copayment** amount, which would cost you three times the **copayment** amount to fill at a retail pharmacy.



4. How do I find out if my current medication is a maintenance drug or what tier my medication is covered under?

To find out if a medication you're presently taking is a maintenance drug or to check the tier of a medication that you're currently taking, please contact Express Scripts at 866-662-0274.

5. How can I find out if the medications I'm currently taking are covered under my prescription drug coverage through the Trust or if I need a prior authorization?

To find out if a medication you're presently taking is covered or will need a prior authorization, please contact Express Scripts at 866-662-0274 and they will assist you.

6. Does anything change in my prescription drug coverage when I become **Medicare** enrolled?

For the most part, no. For **Medicare** enrolled members, the Trust offers a **Part D** prescription drug plan. You'll get a new prescription drug ID card – just make sure you use your new card when you receive it. You will want to check the **Medicare** formulary (commonly used drugs that are covered) as it may differ slightly from the non-Medicare drug plan formulary.

You should also be aware that **Medicare** only allows you to be enrolled in one **Medicare Part D** plan. If you are interested in enrolling in another **Medicare Part D** plan, you must contact RHCC to "opt-out" of the Trust prescription drug plan prior to your effective date to avoid any disruption coverage. If you choose to "opt-out," you will have no Trust-provided prescription drug coverage. If you mistakenly "opt-out," you will have the opportunity to re-enroll.

7. How will my enrollment in this plan impact my existing VA benefits – am I still able to use VA pharmacies?

Yes. If you are eligible for VA benefits, you can still use VA pharmacies under those benefits. Please review the Trust prescription benefit against your VA benefit **copayments** to determine which option makes the most sense for you.

8. Can I keep both my VA and the Trust provided prescription drug coverage?

Yes. You do not have to choose one or the other. You can use the VA at any time and this will not impact your Trust prescription drug coverage.

MEDICARE

1. If I have Medicare how will my claims be processed?

For **Medicare Advantage** plans, the claims are not processed through **Medicare**. Rather, the health insurance carrier processes the claims for the enrollee.

For member in the **TCN** plan, **Medicare** will pay first, and then the Trust will process the remaining balance for payment with any cost-sharing requirements if the claim is a covered service.

2. If I am eligible for Medicare do I have to enroll?

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

It is important for both you and your dependents to enroll in **Medicare** when first eligible. **Medicare Part B** requires a monthly premium. The cost of the **Medicare Part B** premium will go up 10% for each full 12-month period an individual was eligible for **Medicare Part B** during the initial enrollment period but did not enroll.

Surviving spouses must enroll in **Medicare Part A and B** or health care coverage will be terminated.



3. If I'm eligible for **Medicare** but chose not to enroll, how will my claims be processed?

You may not have Trust coverage, as enrollment in **Medicare Parts A and B** are required. That said, health care claims are paid as if **Medicare** is primary whether or not you are enrolled. If you choose not to enroll, you will be responsible for significantly higher out-of-pocket costs.

4. What do I do when I become enrolled for **Medicare Parts A and B**?

When you've enrolled in **Medicare**, contact RHCC and let us know. The Trust will receive your **Medicare** information through the Centers for Medicare and Medicaid Services (CMS).

5. Is there a penalty if I don't enroll in **Medicare Part A or B**?

Yes. It is important for both you and your dependents to enroll in **Medicare** when you are first eligible. You usually don't pay a monthly premium for **Medicare Part A** coverage if you or your **spouse** paid **Medicare** taxes while working. However, if you don't meet those requirements, **Medicare Part A** may require a monthly premium. If you fail to enroll when first eligible, the cost of the **Medicare Part A** premium will go up 10%. You will have to pay that penalty for twice the number of years you could have had **Part A** but did not sign up.

Medicare Part B requires a monthly premium. The cost of the **Medicare Part B** premium will go up 10% for each full 12-month period an individual was eligible for **Medicare Part B** during the initial enrollment period but did not enroll. If you did not enroll when first eligible, and later choose to enroll, you must wait until the next **Medicare Part B** open enrollment period, which is January 1 through March 31 of each year. Your **Medicare Part B** will be effective on July 1 of the year you enroll. For more information on **Medicare**, visit www.Medicare.gov.

6. Does anything change with my health plan coverage when I enroll in Medicare?

Yes. When you enroll in **Medicare**, you will transition to **Medicare** medical coverage. Once you become **Medicare** enrolled, you will have an additional health plan option, a **Medicare Advantage (MA) PPO** plan. **MA PPO** plans are the primary plan for **Medicare**-enrolled Trust members. **MA PPO** plans are offered by a private health insurance company, such as Blue Cross Blue Shield or Aetna, that contracts with **Medicare** to provide you with all your **Part A** and **Part B** benefits. Most **Medicare**-enrolled Trust members are automatically enrolled in the **MA PPO** plan on January 1, following the year they qualify for **Medicare**.

If you decide to enroll in the **TCN** plan, **Medicare** will pay for your health care bills first, then the Trust will cover the remainder for covered services. If you are currently enrolled in an **HMO**, you will be transitioned to a **Medicare Advantage HMO** plan.



7. Who is Public Consulting Group (PCG)?

Public Consulting Group, Inc. (PCG) is a nationally recognized leader in Social Security Administration (SSA) disability benefits representation. PCG combines a wealth of knowledge and expertise with a hands on approach helping individuals file Social Security Disability benefits applications.

The Trust has partnered with PCG to help members obtain Social Security Disability and **Medicare** benefits. Pursuing this is completely your decision, but know this service is offered to you at no cost. If eligible, these benefits may provide you with additional income from Social Security and additional health care benefits available through **Medicare**. Your eligibility for medical benefits provided through the Trust will continue.

PCG also helps Trust **Medicare** members enroll in the Extra Help program. If eligible, this **Medicare** program will reduce your prescription drug **copayments** based on your resource and income defined by **Medicare**.

Feel free to call PCG at 888-690-1008, email your questions: pccguaw@publicconsultinggroup.com, or visit them online: www.ssdiuawtrust.com.

GENERAL

1. Do I need to sign up for a health plan through the health care exchanges?

No. Since you have Trust-provided group health coverage, you do not need to seek coverage through the exchanges.

2. How will my enrollment in this plan impact my existing VA benefits – am I still able to use VA facilities?

Coordination varies depending on the specific circumstance. In general, **Medicare** pays for **Medicare**-covered services, while Veterans' Affairs pays for VA-authorized services. As a general rule, VA and **Medicare** benefits are separate and cannot be combined. Enrolling in a Trust plan will not cause you to lose your VA benefits. When services are received from the VA, the VA will pay. When services are received from a non-VA facility, the Trust plan will pay.

Please note, **Medicare** and VA cannot pay for the same service. Also, most **Medicare Advantage** health plans are not permitted to issue payment to VA Hospitals, Veterans Affairs Medical Centers or Veteran Administration Hospitals for **Medicare Advantage** members with veteran status. This applies to all services and hospital settings, including **emergency**-related claims.



Coinsurance – The member’s share of the costs of a medical service, calculated as a percent of the allowed amount for the service. For example, if the coinsurance was 10%, the plan would pay 90% of the allowed amount and you would be responsible for the remaining 10%. Coinsurance applies after the deductible is met until an applicable out-of-pocket maximum is reached.

Copayment (or Copay) – A fixed-dollar amount that a member may be required to pay to a provider for specific covered services or supplies (such as emergency room visits or prescription drugs) at the time the service or supply is provided. You are responsible for any required copayments, regardless of the status of any applicable deductibles or out-of-pocket maximums.

Deductible – The amount a member may be responsible for paying each calendar year for covered services prior to the plan making a payment. “Single” and “family” deductibles may apply. Once the deductible is met, coinsurance may apply.

Dependent Child(ren) – Generally, a child whom the enrollee can legally claim as an exemption on his or her federal income tax return. To be eligible for coverage under the Trust, the child must meet certain eligibility requirements.

Durable Medical Equipment (DME) – Durable Medical Equipment (DME) is any equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses. DME includes, but is not limited to, wheelchairs (manual and electric), hospital beds, traction equipment, canes, crutches, walkers, oxygen equipment, ventilators, lifts, and blood testing strips for diabetics.

Elective Service – Elective services are a surgery or procedure that is scheduled in advance because it does not involve a medical emergency.

Emergency – An emergency means medical care may be needed immediately and waiting may be dangerous.

Enhanced Care PPO (ECP) – This plan is the primary plan for non-Medicare Trust members. This plan is based on a nationwide network of providers and allows services to be performed both in-network and out-of-network.

Explanation of Benefits (EOB) – A statement from insurers about individual health claims. The EOB should include information about the provider, the date of service, the service itself, charges for the service, how much the insurer considers to be a reasonable price for the service, and the amount paid to the health care provider.

Generic Drugs – A generic drug is a drug which is produced by one or more manufacturers other than the one producing the brand version. The active ingredient in the generic drug is the same as the one in the brand drug. The FDA approves all generic drugs to be functionally the same as brand drugs.

Health Maintenance Organization (HMO) – HMOs only cover care rendered by those doctors and other professionals who have agreed to treat patients in accordance with the HMO's guidelines and restrictions. Generally, a primary care physician coordinates all of the care.

In-Network – The term refers to physicians, facilities, or services that are contracted to a particular carrier.



Medicare – A federal health care program for individuals age 65 or older, and for certain individuals under age 65 who have a severe long-term disability including end-stage renal disease (ESRD). **It has four main parts:**

- **Part A:** Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
- **Part B:** Part B covers certain doctors' services, outpatient care, medical supplies, certain drugs and preventive services.
- **Part C:** A type of Medicare health plan offered by private companies that contracts with Medicare to provide all Part A and Part B benefits.
- **Part D:** Part D covers prescription drug coverage through private plans.

Medicare Advantage Plan (MA) – A type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage plans include Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). If you're enrolled in a MA plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare.

Monthly Contribution – The amount an enrollee may be required to pay monthly for health care coverage. The amount can vary based on enrollment as "single" or "family," "Protected" or "General," or the plan option selected (e.g., TCN or HMO).

Out-of-Network – Hospitals, pharmacies, providers, and special services that are not in the network of the Plan are considered out-of-network. When you use an out-of-network provider, you generally are responsible for paying the out-of-network deductible and coinsurance, as well as any amounts in excess of the allowed amount billed by the provider.

Out-of-Pocket Maximum – A limit on the amount you pay during the year after which the plan will pay for your covered services at 100%. Some cost sharing, such as coinsurance and deductibles, from in-network providers count toward your out-of-pocket maximum. Copay services generally do not count toward out-of-pocket maximums. A separate out-of-pocket maximum may apply for in-network services and out-of-network services.

Preferred Provider Organization (PPO) – A PPO is a plan design that offers a network of physicians, hospitals, and other medical providers that have agreed to provide health care at discounted fees. Participants who are covered under a PPO plan do not need referrals to receive care from in-network or out-of-network physicians, however, out-of-network charges are not paid in full unless referred and approved through the PPO network.

Preventive Services – Services provided for the detection or prevention of illnesses. Preventive services – like most vaccinations and many screening tests – are covered at 100% and excluded from the annual deductible, copayment, and coinsurance requirements.



Rolling Enrollment – A contract holder is able to change their benefit elections once every 12 months. The 12-month period begins when the new elections have been made. The 12-month restriction may be waived when a new health plan is offered in your service area.

Spouse (same-sex or opposite-sex) – An individual who is married to a Retiree with a valid marriage certificate from a state, the District of Columbia, a U.S. territory, or a foreign country (“Jurisdiction”) where such marriage has been recognized as legal according to the laws of that Jurisdiction.

Traditional Care Network (TCN) – The base plan option available to Medicare members. For members in this plan, Medicare is primary and TCN coverage is secondary. This plan is based on a nationwide network of providers and allows services to be performed both in-network and out-of-network.

Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

VEBA – A Voluntary Employees’ Beneficiary Association is a tax-exempt employee welfare benefit fund that is held in trust for the benefit of covered participants. Legally, the Trust is structured as a VEBA, and people sometimes refer to the Trust as “the VEBA.”



Please visit us online for more information on topics covered here. Also, note that most of the materials we send to you in the mail are available for you to download online.

UAW Retiree Medical Benefits Trust
Retiree Health Care Connect (RHCC)
866-637-7555
uawtrust@rhac.com
www.UAWTrust.org

Here are some helpful contact and resources for you to keep handy:

Express Scripts Rx
866-662-0274
www.express-scripts.com

Delta Dental
800-524-0149
www.deltadentalmi.com

Davis Vision
888-234-5164
www.davisvision.com

Medicare
800-MEDICARE
www.medicare.gov

Social Security Administration
800-772-1213
www.SocialSecurity.gov or visit
your local Social Security office

UAW RETIREE
Medical Benefits Trust

