UAW RETIREE Medical Benefits Trust

UAW Union Benefit Representative Resource Guide

This guide provides information on benefits under the UAW Retiree Medical Benefits Trust (the "Trust"). The information included provides additional detail on the medical and prescription drug benefits for 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.

DO NOT DISTRIBUTE WITHOUT PERMISSION

Updated: October 2024

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The UAW Retiree Medical Benefits Trust

The **UAW Retiree Medical Benefits Trust** is the official name of the Voluntary Employees' 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 this guide "**the Trust**."

> The Trust's **mission** 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 well-being 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.

The 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 assume the responsibility for the administration and delivery of eligible retiree medical benefits beginning January 1, 2010. These Agreements were reviewed and approved by federal courts.

The 2007 Settlement Agreements eliminated a series of "all-or-nothing" risks that previously threatened the existence of ongoing medical benefits for UAW retirees. Under the Agreements, however, the Committee is responsible to make sure, on an ongoing 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. It is not operated by the UAW, and has 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. Healthcare 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 ongoing 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 before members so they can answer questions and help retirees understand 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, healthcare coverage is transferred to the Trust, a separate entity from the auto company, the retirement process should begin at least 90 days before the intended effective date. It is important for future members to understand that Trust coverage differs from active coverage in several ways:

- Dependent eligibility rules differ.
- Carriers and plan options may be different.
- PPO plans may 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 may be higher.

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

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 members (under age 65 and without disability). This plan is available in all 50 states. Based on geographical location, there may be additional health plan options available, 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, they will need to enroll in Medicare Part B for an effective date matching the retirement date, 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 they choose to enroll in Medicare. There is no exception based on timing so it will be important that the Medicare effective date matches 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 Medicare 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 members. 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 members will receive new ID cards from the health plan carriers.

A 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.

Life Events & 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 they are responsible for medical coverage due to a divorce decree or Qualified Medical Child Support Order (QMCSO).

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 healthcare 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/healthcare 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, before 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

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 members who are eligible are required to have Medicare Part A to enroll in Trust coverage. If a member does not enroll, they will no longer be eligible for Trust coverage.

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

1. The Trust processes claims as if a member is enrolled in Medicare Part B (regardless of whether a 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 with 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.

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

Address Change

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 the elected healthcare 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 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 days 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.

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.

“Dependent” to “Surviving Spouse” Transition

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

- The 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.
- 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.

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, members must continue to pay their 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, Kentucky, Maryland, Michigan, 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 visits and specialist coverage, the ECP plan features personalized and convenient resources to assist in navigating the health care system. With this plan, members 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 members 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, 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 healthcare plan becomes available, all members in the service area will be allowed 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 ECP plan or an HMO plan, where available.

Prescription Drug Benefits

Most Trust medical plans have prescription drug coverage administered by **Optum Rx** (excluding Kaiser HMO plans). Regardless of the medical plan option the member is 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.

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 Optum Rx customer service.

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 Optum Rx Mail-Order to avoid paying the full cost of the drug at retail.

Optum Rx Mail-Order for Medicare Members

If a Medicare member has not had a prescription filled through mail-order in the past 12 months, to deliver any new prescriptions that a doctor sends directly to Optum Rx, the member needs to approve the new prescription with Optum Rx. Optum Rx 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 Optum Rx to process a renewed prescription, the refills will continue shipping automatically until the prescription expires.

Mail-Order Prescription Payments

Once a member accrues charges, Optum Rx will require payment. Members can pay mail-order charges via check, e-check, money order, or credit card. Extended payment options are available by calling member service.

For interested members, there is an automatic payment program. This uses credit card payments and provides uninterrupted service. Members can enroll online by calling Optum Rx.

- Blue Shield Medicare Advantage Plan: 855-856-0537
- Medicare Plans – TCN, BCN, HAP & Humana: 855-409-0219
- Non-Medicare Plans – ECP, BCN & HAP: 855-409-0219
- UnitedHealthcare Medicare Advantage Plan: 844-320-5021

Medicare & Prescription Drug Coverage

Medicare members in the TCN, BCN, HAP, and Humana plans will be automatically enrolled in the group-sponsored Medicare Part D prescription drug plan for Medicare members offered through Optum Rx. 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 the requirement of a prior authorization for certain medications remains the same.

The UnitedHealthcare and Blue Cross Blue Shield Medicare Advantage plans are MA-PD plans, which means they are Medicare Advantage plans with prescription drug coverage. The prescription carrier for these plans is Optum Rx. This means members enrolled in these plans have one ID card that is used for medical services or at the retail pharmacy.

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 a 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, Optum Rx will work with its Medicare Part B supplier.

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.

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 their Optum Rx formulary.

A coverage review for commercial members 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 Optum Rx Member Services.

- Blue Cross Blue Shield Medicare Advantage members: 855-856-0537
- Medicare members, TCN, BCN, HAP & Humana: 855-409-0219
- Non-Medicare members, ECP, BCN & HAP: 855-409-0219
- UnitedHealthcare Medicare Advantage: 844-320-5021

Erectile Dysfunction Drugs

Erectile Dysfunction drugs include Viagra®, Levitra®, Edex®, Muse®, Caverject®, and Cialis®. Certain strengths of Cialis or tadalafil (2.5 mg and 5 mg only) have a Medicare Part D approved indication (Benign Prostatic Hyperplasia – BPH) and coverage is determined via a prior-authorization process. A coverage review for generic Revatio® or sildenafil (20mg only) only is available in cases where a member is diagnosed by their physician with Pulmonary Arterial Hypertension.

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.

Optum Rx 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 specific Specialty Medications results in dispensing in smaller day supply increments when obtained through mail-order.
- Over 90 days, 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.
- Optum Specialty Pharmacy 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, hearing, vision or OTC) claim that is denied, appeals options are available; however, they must follow the necessary steps on time.

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 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.

Optum Rx Claims & Appeals

Always present the medical or prescription ID card when at the pharmacy to ensure the correct information is submitted for claims. If a claim is denied in whole or in part, members have the right to file an appeal.

They should call Optum Rx to appeal the rejection. Optum Rx will contact the subscriber with instructions on submitting clinical information to support the script. For each appeal, the member and provider will both get a letter of determination.

Notice of Claim Decision/Appeals
Optum Rx will provide a notice of the claim decision. The notice will be in writing and will inform on the specific reasons for the decision. It will refer to the specific provisions of the plan on which the denial is based and explain whether any additional information is required from the member. Optum Rx will decide on the claim within the deadline for the type of claim involved (e.g., urgent claim, prior authorization).

First and second level appeals can be sent to Optum Rx by phone or mail:

Phone: (888) 403-3398

Write to:
C/O Appeals Coordinator
PO Box 2975
Mission, KS 66201

Complete details on filing a claim or appeal can be found in the Summary Plan Description (SPD) available at uawtrust.org/documents.

Members must exhaust all levels of the appeal process with Optum Rx 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 Prior Authorizations

For a medication requiring prior authorization, the member or prescriber can call Optum Rx.

Trust Appeals

If a medical or prescription drug claim is denied in whole or part (self-insured plans only), 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.

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 health care coverage is limited outside the U.S., members may choose to buy a travel insurance policy to get more coverage. An insurance agent or travel agent can provide more information about buying travel insurance.

Resources

There are several resources available to assist with member inquiries.

UAW Retiree Medical Benefits Trust

uawtrust.org

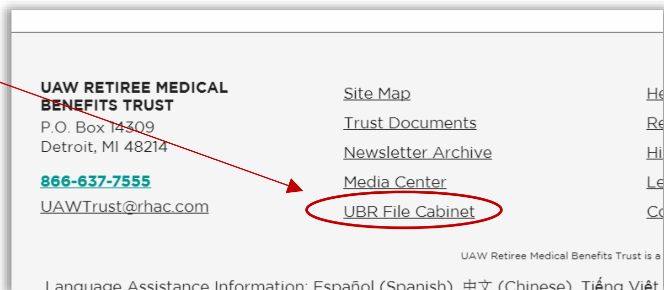
In addition to providing a deeper history of the Trust (its mission, biographies of the Board of Trustees, etc.), the Trust's website also includes detailed information on:

- 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)

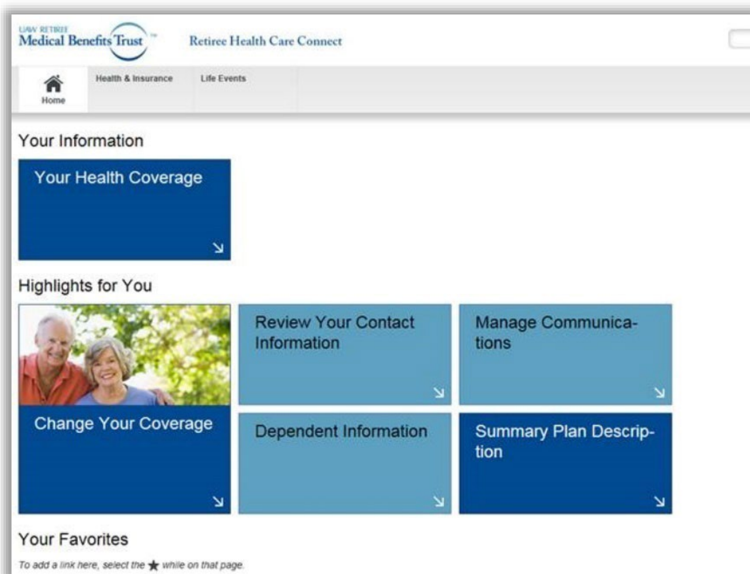
866-637-7555 | Member Portal: http://digital.alight.com/rhcc

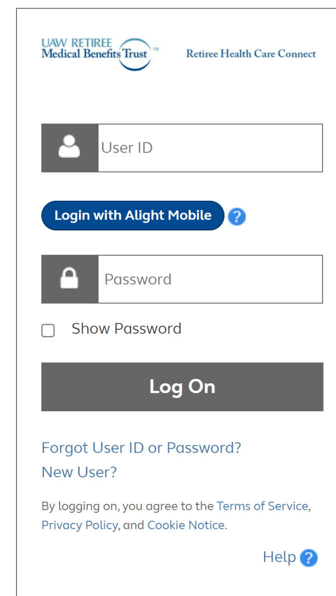
When members first log onto the website, they will need to register by creating a unique User ID and password. To register, members will need the last four digits of their Social Security number, birth date, and ZIP code.

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.)
- Heath care plan modeling
- Request forms





Contact Information

Contacts in RED are for UBR use only (NOT for members).

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 Contact	866-617-2216
Member Experience UBR Contact	memberexperience@rhac.com Fax: 313-324-5950

PLAN CARRIERS	
BCBS TCN & MAPD UBR Contact	800-348-6559
BCBS ECP	Health Guide: 866-507-2850
UHC / OPTUM Rx UBR Contact	https://retiree.uhc.com/ubr
Delta Denta UBR Contact	
GM	866-696-7439
Ford	800-656-6496
Chrysler	855-274-0888
CVS OTC	844-487-2770

OTHER	
Public Consulting Group (PCG) Security Disability Insurance (SSDI)	https://www.ssdiuawtrust.com/ 888-690-1008

For member-facing and other available contact information/resources, visit: uawtrust.org/healthplancarriers