UAW Retirees of the
Dana Corporation Health & Welfare Trust

Benefits for Non-Medicare Eligible Participants

SUMMARY PLAN DESCRIPTION

JANUARY 1, 2013

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Introduction

The UAW Retirees of the Dana Corporation Health & Welfare Trust (Trust) provides medical and prescription drug benefits to eligible participants. This Summary Plan Description (SPD) describes the benefits available as of January 1, 2013 for non-Medicare eligible participants. The Trust has a separate Plan for Medicare-Eligible participants, which is described in another SPD.

UAW Retirees of the Dana Corporation Health & Welfare Trust Benefits

The Trust offers separate health care coverage for non-Medicare eligible and Medicare-eligible participants. This booklet describes the Plan available to non-Medicare eligible participants. When you or a dependent becomes eligible for Medicare, you or your dependent must:

- Sign up for Medicare Parts A and B as soon as you become eligible – coverage under the Plan for Medicare-eligible participants cannot begin until you are enrolled in Part B;
- Notify BeneSys to enroll in the Plan for Medicare-eligible participants – you must send a copy of your Medicare enrollment verification to BeneSys as soon as it is received to continue coverage without a break; and
- Not sign up for an individual Medicare Part D prescription drug plan (unless you do not want to receive either medical or prescription drug coverage from this Trust).

The Trust, which was established February 1, 2008 as part of a bankruptcy settlement between the UAW and Dana Corporation, is sponsored and administered by a Committee of seven members. Four of the Committee members are independent members and three of the Committee members are appointed by the UAW. The Committee manages the Trust, designs and administers the benefit Plan and serves as the legal Plan Administrator and named fiduciary.

The Committee hired BeneSys, Inc. as the Fund Administrator. BeneSys handles general Plan administration, including eligibility, recordkeeping, participant contributions and inquiries.

The Plan is designed to help you meet your medical and prescription drug needs. However, it is your responsibility to know what your benefits are and how to use them. Be sure to:

- **Carry Your ID Cards.** Be sure to carry your medical and prescription drug ID cards with you and show them whenever you receive medical care or need to fill a prescription.
- **Follow Plan Procedures.** Review the information in this SPD so that you are familiar with how the Plan works to ensure you make the most of your benefits.
- **Keep the Fund Administrator Informed of Changes.** You should notify BeneSys of any change in your address, family status (such as marriage, birth, adoption, death, divorce, legal separation or a child losing dependent status) or medical or prescription drug insurance coverage of a family member covered by any of the Plans offered through the Trust.
- **Identify Yourself.** If you need to contact BeneSys, be sure to include your name and the last four digits of your Social Security number in your letter. To protect against identity theft, do not include your complete Social Security number in your letter. If you call, please be sure to have your complete Social Security number handy.

- **Stay Current with your Contributions.** You must make monthly contributions to establish and continue eligibility for benefits. If your contributions are not made on time, your coverage may be cancelled.
- **Keep Copies of Bills, Receipts and Explanations of Benefits (EOBs).** These copies can help you when filing a Claim or appeal.
- **Keep Notices You Receive from the Trust.** Keep any notices of Plan changes or information you receive with this booklet. As a participant in the Plan, you have certain responsibilities to protect your eligibility for coverage and to receive your benefits.
- **Read this Booklet.** Take the time to read this SPD and share it with your family. The information contained in this SPD supersedes any earlier SPD you may have received.
- **Defined Terms:** Terms that have specific meanings relating to this Plan are initial capped throughout this booklet and are defined in the Glossary, which begins on page 68.

If you have specific questions or need any assistance, contact BeneSys:

- **Street Address:** 700 Tower Drive, Suite 300, Troy, Michigan
- **Mailing Address:** P.O. Box 1708 Troy, Michigan 48099-1708
- **Phone:** (866) 626-2070 or (248) 641-4903
- **Fax:** (248) 813-9898
- **Office Hours:** Monday through Friday, 7:30 a.m. to 4:30 p.m.

This SPD describes how the Plan works, what benefits it provides and how to obtain those benefits. This SPD is only a summary of your benefits; full details of the Plan are included in the legal documents that govern this Plan. The UAW Retirees of the Dana Corporation Health & Welfare Trust and the Plan are governed by the Committee. The Committee is the legal Plan Administrator. No one has the authority to speak for the Committee in explaining the eligibility rules or benefits of the Plan, except the full Committee or the Fund Administrator to whom such authority has been delegated. The Committee has the right to interpret the Plan, change or eliminate benefits, or amend or terminate the Plan at any time.

Eligibility and Participation

This section describes the eligibility requirements for individuals eligible for coverage under the UAW Retirees of the Dana Corporation Health & Welfare Trust. **However, this SPD only describes benefits for eligible participants who are *not* eligible for Medicare**; benefits for Medicare-eligible participants are described in a separate SPD.

When you or a dependent becomes eligible for Medicare, you or your dependent must:

- Sign up for Medicare Parts A and B as soon as you become eligible – coverage under the Plan for Medicare-eligible participants cannot begin until you are enrolled in Part B; and
- Notify BeneSys to enroll in the Plan for Medicare-eligible participants – you must send a copy of your Medicare enrollment verification to BeneSys as soon as it is received to continue coverage without a break.

Employee Eligibility

If you meet the eligibility requirements (as described in this section) and want to participate in the Plan, **you must enroll in coverage or elect to defer coverage when your employment with Dana or a former Dana location ends.** If you do not enroll or defer coverage when your employment ends, you cannot elect coverage at a future date.

Retired Employee – Health Care Plan

You are eligible for coverage under this Health Care Plan as a Retired Employee if you are **not** eligible for Medicare (due to age or disability) and you meet **one** of the following two conditions:

1. **Retired Employee Covered under a Dana Plan as of February 1, 2008:** You were an Employee (as defined by the Plan, refer to the Glossary, page 70) who had retired on or before January 31, 2008 and were covered under one of the plans maintained by Dana Corporation under a collective bargaining agreement and/or plant closing agreement with the UAW at that time to provide health care benefits to Retired Employees, subject to the eligibility requirements of those plans.

Or

2. **Retired Pottstown or Lima Employee:** You were an Employee (as defined by the Plan, refer to the Glossary, page 70) hired before November 1, 2003 who terminated employment after January 31, 2008, from the Pottstown, PA or Lima, OH Dana facility while eligible for Retired Employee health care benefits under a UAW Master Agreement, with at least eight years of credited service, you retired directly from active service without a break ***and*** you:
   - Are age 65 or older;
   - Are age 60 or older with 10 or more years of credited service;
   - Are age 55 with 85 or more combined years of age and credited service;

- Have 30 or more years of credited service; ***or***
- Were on the active payroll (or would have been on the active payroll except for an Illness leave of absence) within 12 months of being laid off due to a cessation of operations at age 55 or older with 10 or more years of credited service (provided that the number of months following your layoff does not equal the number of months of credited service as of your layoff).

Retired Employee – Retiree Flex Plan

Note: The Retiree Flex Plan is a separate plan, which is described in another SPD.

You are eligible for coverage under the Retiree Flex Plan as a Retired Employee if you are **not** eligible for Medicare due to age or disability and you meet **one** of the following two conditions:

1. **Retired Auburn Hills Employee:** You were an Employee (as defined by the Plan, refer to the Glossary, page 70) hired before January 1, 2004 who terminated employment after January 31, 2008 from the Auburn Hills, MI Dana facility with eligibility for Retired Employee benefits under the Retiree Flex Plan, you retired directly from active service without a break ***and*** you are:
   - Age 65 or older with any amount of credited service; ***or***
   - Age 50 or older with 10 or more years of credited service with 70 or more combined years of age and credited service.

Or

2. **Retired Elizabethtown Employee:** You were an Employee (as defined by the Plan, refer to the Glossary, page 70) hired before January 1, 2004 who terminated employment after January 31, 2008 and before March 8, 2010, from the Elizabethtown, KY facility, you retired directly from active service without a break ***and*** you are:
   - Age 65 or older with any amount of credited service; ***or***
   - Age 50 or older with 10 or more years of credited service with 70 or more combined years of age and credited service.

Disabled Employee

You are eligible for coverage under this Plan as a Disabled Employee if you are **not** eligible for Medicare (due to age or disability) and, upon cessation of your long-term disability benefits, you immediately begin your retirement benefits and meet **one** of the following:

1. **Disabled Employee Eligibility:** You were listed by Dana and the UAW as being on long-term disability status as of January 31, 2008 and have been continuously disabled and eligible since that date.

Or

2. **Disabled Employee Eligibility:** You were an Employee (as defined by the Plan, refer to the Glossary, page 70) who began a Continuous Period of Disability on or before January 31, 2008 and have been continuously disabled (as defined by the Plan) since that date, but are no longer entitled to receive short-term disability benefits ***and***:

   - You were a full-time hourly Employee employed as of the date you became disabled at a Dana facility located in:
     - Angola, IN;
     - Antwerp, OH;
     - Ashland, OH;
     - Auburn, IN;
     - Berwick, PA;
     - Chelsea, MI;
     - Chicago, IL;
     - Ecorse, MI;
     - Fort Wayne, IN;
     - Columbia City, IN (brake plant);
     - Hagerstown, IN;
     - Hamtramck, MI;
     - Lansing, MI;
     - Lima, OH;
     - New Castle, IN;
     - Plymouth, MN;
     - Pottstown, PA;
     - Richmond, IN;
     - Rushville, IN;
     - Syracuse, IN;
     - Toledo, OH; *or*
     - Warren, MI; ***and***
   - You meet the definition of disability because you are:
     - Wholly and continuously disabled due to an Illness or Injury;
     - Under the care of a licensed Physician;
     - Completely prevented by your disability from engaging in any regular employment at the plant or plants where you have seniority under a collective bargaining agreement; *and*
     - Are not engaged in any regular employment or occupation.

Or

3. **Disabled Employee Eligibility:** You were an Employee (as defined by the Plan, refer to the Glossary, page 70) who began a Continuous Period of Disability on or before January 31, 2008, but are no longer entitled to receive short-term disability benefits **and**:

   - You were a full-time hourly Employee employed as of the date you became disabled at a Dana facility located in:
     - Auburn Hills, MI;
     - Bristol, VA;
     - Buena Vista, VA;
     - Cape Girardeau, MO; or
     - Elizabethtown, KY;
   - You meet the definition of disability because you are:
     - Wholly and continuously disabled because of an Illness or Injury; *and*
     - Under the care of a licensed Physician;
   - During the first six months after short-term disability benefits end, you are completely prevented by the disability from performing duties associated with any other position you held immediately before the disability or any other position available at the same facility for which you are reasonably qualified by education, training or experience;

- For periods thereafter, you are completely prevented by your disability from engaging in any gainful occupation for which you are reasonably qualified by education, training or experience and you cannot earn a living through any other means; ***and***
- You are not regularly employed elsewhere.

If you are a Disabled Employee who retires directly from disability status, you will continue to be covered under the Plan, subject to meeting all other eligibility requirements

Spouse Eligibility

Your non-Medicare eligible Spouse (as defined by the Plan, refer to the Glossary, page 73) is eligible for coverage if you are an eligible:

- Retired Employee and your Spouse was married to you as of the date of your retirement; or
- Disabled Employee and your Spouse was married to you as of the date your Continuous Period of Disability (entitling you to benefits) began.

Surviving Spouse Eligibility

You are eligible for coverage under this Plan as a Surviving Spouse (as defined by the Plan, refer to the Glossary, page 74) if you are **not** eligible for Medicare (due to age or disability) and you meet **one** of the following:

1. **Surviving Spouse Eligibility:** You were married to a Retired Employee on the date of his or her retirement and on the date of his or her death, or you were married to an eligible Disabled Employee on the date of his or her disability and the date of his or her death.

Or

2. **Surviving Spouse Eligibility:** You were married to an Employee and on the date of his or her death, he or she would have been eligible for coverage under the Plan as a Retired Employee had he or she terminated employment at that time.

Or

3. **Surviving Spouse Eligibility:** You were married to an eligible Employee who died due to an on-the-job Injury while employed at a Dana facility.

For a Surviving Spouse to continue coverage, he or she must submit a complete and accurate enrollment application to BeneSys no later than 30 days after the date of the Employee's death.

Note: If you are a Surviving Spouse of a Retired Employee covered under the Retiree Flex Plan, you could contact BeneSys about your eligibility to continue Surviving Spouse coverage under this Plan.

Dependent Child Eligibility

The Dependent Child (as defined by the Plan, refer to the Glossary, page 69) of a Retired or Disabled Employee or Surviving Spouse is eligible for coverage if he or she is:

- Not married; and
- Under age 19 or age 25 if a full-time student.

As long as a Dependent Child is otherwise eligible, coverage will continue until the last day of the Calendar Year in which the Dependent Child reaches age 19. However, coverage may be extended until the last day of the Calendar Year in which the Dependent Child reaches age 25 if the Dependent Child:

- Is enrolled as a full-time student at an accredited high school, college, university or vocational training school;
- Lives with the Retired or Disabled Employee or Surviving Spouse; and
- Can be claimed by the Retired or Disabled Employee or Surviving Spouse as a dependent for federal tax purposes.

In addition, coverage may be continued beyond the above age limits if the Dependent Child is disabled and adequate annual proof of disability is provided.

Disabled Dependents

A Dependent Child may continue to receive benefits after the Dependent Child reaches the maximum age (19 or 25 if a full-time student) if the Dependent Child is incapable of self-sustaining employment because of physical or mental incapacity or disability developed before the Dependent Child reaches age 19 (or 25 if a full-time student). Proof of incapacity or disability acceptable to the Committee (or its designee) must be provided within 31 days of the date on which the Dependent Child's status as a dependent would otherwise end. In addition, proof of continued incapacity or disability must be provided on an annual basis. Provided annual proof of continued eligibility is provided and the Dependent Child otherwise meets eligibility requirements, coverage may continue until the Dependent Child dies or the Committee determines that the child is no longer disabled or incapacitated.

Qualified Medical Child Support Orders

As required by federal law, the Plan recognizes Qualified Medical Child Support Orders (QMCSOs). A QMCSO is a court order that recognizes the right of an alternate recipient (Dependent Child) to receive Plan benefits. A QMCSO is usually issued in a divorce where an individual is ordered by the court to continue to provide medical support for their child(ren); it may also be in the form of a National Medical Support Notice (NMSN) issued by the Friend of the Court. A QMCSO may not require the Plan to provide a type or form of benefit not otherwise provided to eligible Dependent Children.

When BeneSys receives an order that may be a QMCSO, BeneSys or Trust legal counsel will determine if it is a QMCSO. If the document is determined to be a QMCSO, the Trust will notify the eligible Covered Person and the possible alternate recipient (or custodial parent or issuing agency, as appropriate). If the document is determined not to be a QMCSO, the Trust will send a letter describing the reason for that determination. Payment of benefits made by the Plan pursuant to a QMCSO may be made to the alternate recipient's custodial parent or legal guardian, and notices and explanations of benefits relating to the alternate recipient will be sent to the custodian parent or legal guardian. Plan coverage of a Dependent Child under a QMCSO will be provided for as long as the child satisfies the definition of a Dependent Child for the applicable Benefits, the required monthly contributions are made to the Trust for the period of coverage indicated in the QMCSO and the QMCSO remains in effect.

Contributions for Coverage

Contributions are required for coverage. If monthly contributions are not made on time, coverage will end. To avoid cancellation of your and your dependent's coverage, you must make the required contributions on time. To make your contributions, you may:

- Sign up for automatic monthly pension deductions;
- Sign up for automatic monthly deductions from your bank account; or
- Pay by check (an additional monthly check-processing fee may apply).

Keep in mind that if you elect to pay by check, it is your responsibility to ensure your payment is made, on time, each month.

Contact BeneSys for current contribution amounts, forms needed to elect automatic deductions or if you have any questions about your monthly contributions. Contributions amounts are subject to change; you will be notified of any change.

Enrolling for Coverage and When Coverage Begins

When you first become eligible for the Plan, you must complete an enrollment application for yourself and your Spouse and dependents and file it with BeneSys. For a:

- Retired or Disabled Employee, you must submit your application no later than the first day of the month before the month the retirement begins; or
- A Surviving Spouse who becomes eligible for coverage because of the death of an Employee, you must submit your application no later than 30 days after the date of the Employee's death.

A Retired or Disabled Employee, but not a Surviving Spouse, may enroll a newly eligible Dependent Child. Written notice must be provided to BeneSys with all required documentation (such as birth certificates, proof of guardianship, adoption papers, marriage certificates, etc) within 30 days of becoming eligible. Coverage for new dependents will not begin before the notice and the documentation are received, so it is to your benefit to provide the notice and the documentation to BeneSys as quickly as possible.

Your coverage under this Plan begins on the first day after your prior coverage ends if you have no interruption in coverage and you notify BeneSys that you want to enroll in the Plan within 30 days after your qualified coverage ends.

If you do not enroll yourself or a new dependent as required when initially eligible, you will not be able to enroll in the Plan, unless you meet the requirements for delayed enrollment.

Monthly contributions are required for coverage. You will be notified of the monthly cost of coverage when you are initially eligible as well as periodically thereafter. Contribution amounts are established by the Committee and are subject to change. You will be notified of any change.

Delayed Enrollment

You may delay enrollment in the Plan if you meet all other requirements for enrollment and participation in the Plan, including paying required monthly contributions and you:

- Have qualified coverage in another group health plan (this means continuous participation in a group health plan that provides medical benefits and is maintained by an employer, former employer, employer organization, employees' beneficiary association or the United States Armed Forces) and notify BeneSys that you want to delay enrollment and provide satisfactory evidence of your qualified coverage within 30 days of when you are eligible for this coverage; or
- Lose qualified coverage involuntarily (this means not by choice, but because the plan providing the qualified coverage is terminated or stops covering you because you or your Spouse ceases employment with an employer maintaining the plan or for another reason) and you submit a delayed enrollment application to BeneSys (along with proof of creditable coverage or other satisfactory evidence of continuous qualified coverage) within 30 days after your qualified coverage ends; and
- If you do not request delayed enrollment as described above or you do not provide proof of qualified coverage, you may still enroll in the Plan if you:
    - Submit an enrollment application to BeneSys; and
    - Meet all other requirements for enrollment and coverage, including making your monthly contributions.

Coverage due to a delayed enrollment will not begin until the first of the month following 90 days after BeneSys accepts your delayed enrollment materials. Any Claims incurred before your coverage effective date will not be covered by the Plan.

Contact BeneSys with any questions about delaying your enrollment.

To transition without a break in coverage from this Plan to the Plan for Medicare-eligible participants, you must:

- Enroll for Medicare Parts A and B as soon as you become eligible; and
- Immediately notify BeneSys to enroll in coverage for Medicare-eligible participants.

You will not be able to enroll in the Plan for Medicare-eligible participants until you are eligible under that Plan's rules and Medicare's rules, which means that you must be covered under Medicare Parts A and B. If you are not covered under Medicare, this may cause you to lose medical coverage for a period.

Continuing Coverage

Once you have established initial eligibility for Plan benefits, you must meet certain requirements to maintain your eligibility for coverage. The most important requirement is that you pay the required monthly contribution amounts on time. ***If your monthly contributions are not made on time, your coverage will end.***

The Plan provides three ways for you to pay the required monthly contribution:

- Automatic deductions from your monthly pension;
- Automatic monthly deductions from your bank account; or
- Payment by check. If you pay check, BeneSys must receive your payment by the first day of the month of coverage for which payment is being made. For example, your payment for November must be received by BeneSys before November 1. There is a $5 service fee for each contribution payment made by check. The service fee, which is subject to change, must be added to the amount of your monthly contribution.

Payment by automatic method, either pension or bank account deduction, eliminates worry over getting your contribution to BeneSys on time – and, it eliminates the additional check processing fee. If you are not using one of these automatic payment methods, contact BeneSys for information on how to set up automatic payment.

When Coverage Ends

Benefits will not be paid for any Claims incurred after your coverage ends, except as specifically provided in this Summary Plan Description. In some cases, coverage under this Plan can be extended beyond the date it would normally end, as explained in this section. Coverage for non-Medicare eligible Spouses and Dependent Children can be extended as described in the COBRA Continuation Coverage section, beginning on page 14.

Retired Employee or Surviving Spouse

As a Retired Employee or Surviving Spouse, you are no longer covered under the Plan on the earliest of the:

- Date of your death;
- Last day of the month before the month for which the Trust does not receive your required contribution;
- Date you are eligible for Medicare; or
- Date the Plan terminates.

While coverage for a Surviving Spouse does not end if the Surviving Spouse remarries, the Surviving Spouse cannot add any new dependents. The new spouse of a Surviving Spouse and any newly acquired dependents are not eligible for Plan coverage.

Disabled Employee

As a Disabled Employee, you are no longer covered under the Plan on the earliest of the:

- Date of your death;
- Date you are no longer considered a Disabled Employee, as defined by the Plan, and you are not eligible for retirement or your do not retire;
- Last day of the month before the month for which the Trust does not receive your required contribution;
- Date you are eligible for Medicare; or
- Date the Plan terminates.

Spouse

As a Spouse of a Retired or Disabled Employee, you are no longer covered under the Plan on the earliest of the:

- Date of your death;
- Date of your divorce or legal separation from a Retired or Disabled Employee;
- Last day of the month before the month for which the Trust does not receive your required contribution;
- Date you are eligible for Medicare; or
- Date the Plan terminates.

Dependent Children

A Dependent Child is no longer covered under the Plan on the earliest of the:

- Date of the dependent's death;
- Date on which the child no longer meets the Plan's definition of a Dependent Child;
- Date on which the Retired or Disabled Employee or Surviving Spouse with whom the dependent is covered dies or is no longer covered by the Plan;
- Last day of the month before the month for which the Trust does not receive your required contribution;
- Date the child is eligible for Medicare; or
- Date the Plan terminates.

Extended Coverage

For Spouses

Coverage for the Spouse of a Disabled Employee may continue coverage for up to six months after the Disabled Employee's death:

- The Disabled Employee was a full-time hourly Employee when his or her disability began at the Dana facility in:
    - Plymouth, MN;
    - Syracuse, IN;
    - Pottstown, PA; or
    - Lima, OH; and
- At the time of the Disabled Employee's death the:
    - Spouse is at least age 45 but not older than age 60; or
    - Spouse's age plus the Disabled Employee's credited service is greater than or equal to 55.

For Dependent Children

An extension of coverage may be available for the Dependent Child of an Employee who died due to an on-the-job Injury while employed at a Dana facility located in:

- Angola, IN;
- Antwerp, OH;
- Columbia City, IN (brake plant);
- Columbia City, IN (tool plant);
- Fort Wayne, IN;
- Lima, OH;
- Plymouth, MN;
- Pottstown, PA; or
- Syracuse, IN.

Contact BeneSys for more information on this extension.

In addition, benefits may continue for up to four months for a Dependent Child who is waiting to become covered under his or her own employer's health care plan, or until the employer coverage begins, if earlier.

If you are eligible for this Plan because of a disability but you are not yet eligible for Medicare, you may lose your coverage under this Plan when you become eligible for Medicare. However, you may be eligible for coverage under the Plan for Medicare eligible participants. Contact BeneSys for more information.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, this Plan is considered a group health plan that is subject to COBRA. COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a qualifying event. Specific qualifying events are listed below. COBRA continuation coverage is offered to each person who is a qualified beneficiary. Qualified beneficiaries who elect COBRA continuation coverage must pay for this coverage.

Qualified Beneficiaries

A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Qualified beneficiaries include:

- The covered Spouse of a retiree or disabled participant; and
- The Dependent Child of a Retired Employee, Disabled Employee or Surviving Spouse.

In general, for a qualified beneficiary to be eligible to elect COBRA continuation coverage, he or she must have been covered under the Plan on the day before the event that would otherwise cause coverage to terminate. However, any Dependent Children born to or placed for adoption with a qualified beneficiary while covered under COBRA will be covered under the Plan if the birth or adoption is reported within 31 days of the event.

Qualifying Events

COBRA continuation coverage may be purchased as follows:

- **Retired or Disabled Employee's Spouse (other than a Surviving Spouse):** A covered Spouse of a Retired or Disabled Employee may elect COBRA continuation coverage for up to 36 months if the:
  - Covered Retired or Disabled Employee dies; or
  - Spouse and the covered Retired or Disabled Employee divorce or legally separate.
- **Dependent Children:** A covered Dependent Child of a Retired Employee, Disabled Employee or Surviving Spouse may elect COBRA continuation coverage for up to 36 months if the:
  - Retired or Disabled Employee or Surviving Spouse dies; or
  - Covered dependent no longer meets the Plan's definition of an eligible dependent.

Notify the Fund Administrator of Qualifying Events

You must notify BeneSys within 60 days of when a qualifying event occurs, including the death of a Retired Employee, Disabled Employee or Surviving Spouse, or divorce or legal separation. Notification should be sent to:

BeneSys
P.O. Box 1708
Troy, Michigan 48099-1708

A qualified beneficiary must notify BeneSys, in writing, of his or her election for COBRA continuation coverage **during the 60-day election period.** *Once the 60-day election period has passed, the election to decline COBRA continuation coverage cannot be changed.*

Electing COBRA Continuation Coverage

Once BeneSys receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualifying beneficiary. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Parents may elect COBRA continuation coverage on behalf of their Dependent Children.

If you inform BeneSys that you want COBRA continuation coverage but you do not specify whether you want single or other coverage, BeneSys will assume that you want to cover all eligible qualified beneficiaries. If a qualified beneficiary is totally incapacitated and is not legally competent to make an election for COBRA continuation coverage, the 60-day election period is suspended until the qualified beneficiary is able to make an election or until a guardian or legal representative is appointed who can make the election on behalf of the qualified beneficiary.

Failure to notify the Fund Administrator of a qualifying event within the time limit will result in the permanent loss of COBRA rights.

If you initially elect not to continue coverage under COBRA, you may revoke that choice and decide to receive COBRA continuation coverage at any time during the 60-day election period. However, in that case the Plan will only provide COBRA continuation coverage beginning with the date you inform BeneSys that you want continuation coverage, and back to the date of the qualifying event. This will result in a lapse of continuous coverage under the Plan.

COBRA continuation coverage must be elected no later than 60 days after receipt of the COBRA Election Form. ***If the COBRA Election Form is not submitted by the due date, you will lose your right to elect COBRA continuation coverage.***

Coverage Under COBRA

COBRA continuation coverage is the same coverage that is available to other similarly situated non-COBRA beneficiaries covered under the Plan. However, the Fund Administrator reserves the right to terminate a qualified beneficiary's COBRA continuation coverage retroactively if the qualified beneficiary is determined to be ineligible.

If coverage under the Plan is modified for non-COBRA beneficiaries, the coverage under the Plan will be modified in the same manner for all COBRA qualified beneficiaries.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage lasts until the earliest of:

- 36 months after the date of the qualifying event;
- The date on which coverage ends due to failure to make timely COBRA premium payments;
- The date the qualified beneficiary first becomes entitled to Medicare, under Title XVIII of the Social Security Act;
- The date the qualified beneficiary first becomes covered under any other group health plan that does not contain any pre-existing condition limitation;
- The date the Plan terminates; or
- The date a qualified beneficiary provides written notice that he or she wants to end COBRA continuation coverage.

COBRA Continuation Coverage Cost

A monthly premium must be paid for COBRA continuation coverage. The premium is equal to the Trust's full cost of coverage, plus a 2% administrative surcharge.

You have a grace period of 30 days to pay the monthly COBRA payment, except for the first monthly payment, for which there is a one-time-only 45-day grace period. The first monthly premium payment must include all past amounts to the date of election and will apply to the COBRA continuation coverage period beginning immediately after the coverage under the Plan terminates (except for cases where the qualified beneficiary does not elect to continue coverage and then revokes that decision within the election period).

The Plan is not required to pay for any Claims incurred before a timely election of COBRA continuation coverage and proper premium payment for such COBRA continuation coverage; however, such Claims will be eligible for payment after you elect and pay the premium for COBRA continuation coverage by the required due date.

Keep the Fund Administrator Informed

To protect your family's rights, you should keep BeneSys informed of any changes in your address and the addresses of family members. In addition, notify BeneSys of any changes in your family status, such as births, deaths, legal separation, divorce, entitlement to Medicare, etc. You should keep a copy, for your records, of any notices you send to BeneSys.

Questions About COBRA Continuation Coverage

If you have any questions or need additional information about COBRA, contact the Fund Administrator at:

BeneSys
P.O. Box 1708
Troy, Michigan 48099-1708
(248) 641-4903 or (866) 626-2070
Fax: (248) 813-9898

Medical Benefits

The Trust provides medical benefits for non-Medicare eligible participants through Anthem Blue Cross Blue Shield of Wisconsin (referred to as Anthem).

For more information about this Plan, contact BeneSys or Anthem:

- Online at www.anthem.com; or
- By phone at the telephone numbers on your ID card.

How the Plan Works

- **Contributions:** To be covered under the Plan, you must make your contributions to the Trust.
- **Preferred Provider Organization (PPO) Network:**
  - A PPO is a network of Physicians, specialists and Hospitals.
  - The Plan's PPO network is administered by Anthem. Anthem contracts with a network of Hospitals, Physicians and other Providers.
  - Every time you need care, you have the option of using a Provider in the PPO network (in-network Provider) or one that does not participate in the PPO network (out-of-network Provider).
  - What the Plan pays for most covered services depends on if you use an in-network or out-of-network Provider. Generally, the Plan pays a higher percentage when you use in-network Providers.
  - See the Preferred Provider Organization (PPO) section, beginning on page 19, for more information.
- **Annual Deductible:** Each Calendar Year, between January 1 and December 1, you are responsible for paying a certain amount of covered expenses before the Plan begins to pay most benefits.
  - The deductible applies separately to each person.
  - Once you or a family member meets your individual deductible, you or your family member are not required to meet any further deductibles for the remainder of the Calendar Year. Once your family members reach the family maximum, no further individual deductibles are required for the remainder of the Calendar Year.
  - The annual deductibles for in-network and out-of-network care are separate and do not count toward each other.
  - All covered expenses are subject to the deductible unless specifically noted otherwise.
- **Copayment:** A copayment is a flat dollar amount that you pay for certain covered services, such as office visits and emergency room care.
  - Copayments do not apply toward meeting the annual deductible or out-of-pocket maximum.
  - Copayments do not apply to out-of-network Provider services.

- **Coinsurance:** Once you meet your individual deductible (or family members meet the family maximum), you and the Plan share the cost of covered services.
  - The amount the Plan pays varies depending on the service and whether you use in-network or out-of-network Providers.
  - The percent the Plan pays for in-network Providers is generally higher than what is paid for out-of-network Providers.
  - For out-of-network Providers, the Plan pays a percent of the Usual and Customary (U&C) charge. U&C is the amount Anthem determines is consistent with what other Providers in a given geographical area for eligible services, supplies and other medical costs. This is the maximum amount the Plan will pay; you are responsible for charges that exceed the U&C amount.
- **Annual Out-of-Pocket Maximum:** Once amounts you pay for covered expenses reach the out-of-pocket maximum, the Plan pays 100% of most covered expenses for the remainder of the Calendar Year.
  - The out-of-pocket maximum applies separately to each person.
  - Once you or a family member meets your individual maximum, the Plan begins paying 100% for you or your family member;
  - Once your family members reach the family maximum, the Plan begins paying 100% for all covered family members.
  - Copayments, amounts you pay toward your deductible, charges for non-covered services, amounts over U&C and any pre-certification penalties do not count toward the out-of-pocket maximum.
  - The in-network and out-of-network maximums are separate and do not count toward each other.
- **Maximum Benefits:** Certain covered expenses may be limited to an annual or lifetime maximum, as described in the Schedule of Benefits, beginning on page 24.
  - Lifetime maximums refer to the maximum the Plan will pay for a covered service for a Covered Person during his or her lifetime.
  - Plan payments for in-network and out-of-network expenses apply to any maximum.

Preferred Provider Organization (PPO)

With a Preferred Provider Organization (PPO) network, you have access to a network of Hospitals, Physicians, specialists and other health care Providers (in-network Providers) who have agreed to charge negotiated rates. When you use an in-network Provider, you save money for yourself and the Trust because the negotiated rates are generally less than what the Provider usually charges. In addition, when you use an in-network Provider, you save money because the Plan generally pays a higher percentage of covered expenses.

It is your decision whether to use an in-network or out-of-network Provider. You always have the final say about the Providers you and your family use. However, if you use an out-of-network Provider and their fee is higher than the Usual and Customary charge, you must pay the difference between what the Plan will pay and what the Provider charges.

Finding an In-Network Provider

To find an in-network Provider, contact Anthem by:

- Going online to www.anthem.com; or
- Calling (800) 810-2583.

Remember that if you receive covered services from an out-of-network Provider, your out-of-pocket expenses may be higher. So, be sure to contact Anthem to find out who participates in the network.

Unless specifically noted otherwise, covered services received from an out-of-network Provider are always paid at the out-of-network level. If an in-network Provider refers you to an out-of-network Provider, this does not mean that benefits will be paid at the in-network level.

Anthem contracts with Physicians and facilities separately. For example, you could receive covered services at an in-network Hospital by an out-of-network Provider. The Plan considers each Provider's Claim individually. As a result, portions of a Claim for a particular covered service may be paid at the in-network level and others portions at the out-of-network level.

BlueCard Program

The BlueCard Program is a national program comprised of Blue Cross and Blue Shield plans, which allows you to receive covered services from Providers who have a contract or agreement with another Blue Cross and/or Blue Shield plan located outside the geographical area served by Anthem. The local Blue Cross and/or Blue Shield plan that services the geographic area where the covered service is provided is referred to as the host Blue Cross and/or Blue Shield plan. To find a BlueCard Program Provider visit www.anthem.com or call (800) 810-2583.

Health Care Management

Anthem provides health care management services to help you make the most of your health care benefits while receiving quality, cost-effective medical care.

Health care management services include:

- **Pre-Certification:** A required review of certain services, treatments or admissions before they occur to evaluate Medical Necessity and coverage by the Plan.
- **Pre-Determination:** An optional, voluntary request for a determination on whether a service or treatment will be covered before it is received. Generally this involves a review of Plan provisions to determine if there is an exclusion or related clinical coverage guideline for the service or treatment.

- **Post-Service Clinical Claim Review:** A review of a determination of the Medical Necessity or Experimental/Investigational nature of a service, treatment or admission after it has occurred or been received (retrospective). These reviews are generally initiated by Anthem when a service, treatment or admission has a related clinical coverage guideline.
- **Care Management:** A program that helps coordinate and maximize treatment of serious, complex and/or chronic medical conditions.

Pre-Certification

Pre-certification is required for certain services. Generally, an in-network Provider will coordinate this process for you. However, for out-of-network services, it is your responsibility. If pre-certification is required, but not requested (either by your Provider or you), a retrospective review will be completed to determine if care was Medically Necessary. **You are responsible for any charges that Anthem determines are not Medically Necessary.**

Pre-certification is not a guarantee of coverage or payment. Benefits are only paid if, on the date you receive service:

- You are eligible for benefits;
- The treatment or supplies are covered by the Plan;
- The treatment or supply is not excluded by the Plan; and
- You not have exceeded any applicable Maximum Benefit.

The following services and supplies require pre-certification:

- Inpatient admissions:
    - Elective admissions;
    - OB-related medical stays (OB complications, excludes childbirth);
    - Newborn stays beyond mother's stay (for childbirth admissions, pre-certification is not required unless there is a complication and/or the mother and baby are not discharged at the same time);
    - Acute Mental Health and/or Substance Abuse admissions (including partial hospitalization);
    - Long Term Acute Care (LTAC) facility admissions;
    - Inpatient Skilled Nursing Facility admissions; and
    - Rehabilitation facility admissions.

  Emergency admissions do not require pre-certification; however, notification is required within two business days of the admission.
- Outpatient services:
    - Intensive Mental Health and/or Substance Abuse outpatient therapy;
    - Electric Convulsive Therapy (ECT);
    - Uvulopalatopharyngoplasty (UPPP) surgery (correction for sleep apnea);

- Plastic/reconstructive surgeries, including, but not limited to:
  - Blepharoplasty (eyelid surgery);
  - Rhinoplasty (nose surgery);
  - Panniculectomy and lipectomy (fat removal);
  - Diatasis recti repair (“tummy tuck”);
  - Insertion/injection of prosthetic material collagen implants; and
  - Chin implant/mentoplasty/osteoplasty mandible;
- Durable Medical Equipment (DME) and prosthetics; pre-certification should be requested for all DME, including, but not limited to:
  - Wheelchairs (special size, motorized or powered and accessories);
  - Hospital, rocking and air beds;
  - Electronic or externally powered prosthetics; and
  - Custom made orthotics and braces;
- Positron Emission Tomography (PET) (3-D nuclear medicine imaging);
- Private duty nurse services in a home setting; and
- Lumbar spinal surgeries (fusion only).

- Human organ and bone marrow/stem cell transplants, including:
  - All inpatient admissions; and
  - All outpatient services for stem cell/bone marrow transplant (with or without myeloablative therapy) and donor leukocyte infusion.

Once pre-certification is requested, Anthem will work directly with you or your requesting Provider. You may designate an authorized representative to act on your behalf for a specific request. Your authorized representative can be anyone who is 18 years of age or older.

As noted earlier, generally, an in-network Provider will coordinate the pre-certification process for you. For pre-certification purposes, an in-network Provider may include:

- BlueCard Program Providers in the Anthem Blue Cross Blue Shield service area, which includes: CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI);
- Anthem Blue Cross (CA);
- Empire Blue Cross Blue Shield;
- Blue Cross Blue Shield of Georgia; and
- Any future affiliated Blue Cross and/or Blue Shield plans merged into or acquired by the Claims Administrator’s parent company.

You are responsible for requesting pre-certification in all other circumstances, including, but not limited to, services provided by BlueCard Program Providers outside the service areas listed above and any out-of-network Provider.

Pre-certification is not required to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology in the Medical Claims Administrator's network. However, the health care professional may be required to comply with certain procedures, including requesting pre-certification for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating obstetrical or gynecological health care professionals, contact Anthem.

Health Care Management Program

Anthem's Health Care Management Program is designed to help promote the timely coordination of health services for serious, complex and/or chronic medical conditions.

Participation in this Program is confidential and voluntary; it is provided at no additional cost and does not affect covered services in any way. If you meet Program requirements, Anthem may contact you to participate. If you agree to participate, a licensed health care professional will work with you to complete an assessment and develop an individualized health plan to meet your identified needs. The licensed health care professional coordinates your care with you and/or your designated representative, treating Physician(s) or other Providers. The licensed health care professional may also assist with coordinating your care with existing community-based programs and services.

Participating in the Health Care Management Program is not a guarantee of benefits; care and treatment are subject to all Plan provisions.

Schedule of Benefits

The following table highlights what you and/or the Plan pays for covered expenses. More information about covered expenses is included in the following section. For out-of-network Providers, the Plan bases payment on the Usual and Customary charge. Any amounts in excess of U&C are your responsibility.

Plan Feature	In-Network	Out-of-Network
Annual Deductible	$300 per person $600 family maximum	$600 per person $1,200 family maximum
Coinsurance	Plan pays 80% after deductible (unless noted otherwise)	Plan pays 60% of U&C after deductible (unless noted otherwise)
Annual Out-of-Pocket Maximum	$1,500 per person $3,000 family maximum	$4,500 per person $9,000 family maximum
Lifetime Maximum	$5,000,000 per person (combined in-network and out-of-network)	$5,000,000 per person (combined in-network and out-of-network)
Hospital Services—Inpatient (pre-certification required)	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Physician Services (copayments apply to exam charge only)		
Primary Care Physician	You pay $20 copayment per visit; no deductible	Plan pays 60% of U&C after deductible
Specialist	You pay $30 copayment per visit; no deductible	Plan pays 60% of U&C after deductible
Laboratory Services—Outpatient	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Radiology, Nuclear Medicine, Radiation Therapy—Outpatient	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Emergency Room Services (medical emergency only)	You pay $100 copayment per visit; no deductible Copayment waived if admitted for inpatient services	Plan pays 60% of U&C after deductible

Plan Feature	In-Network	Out-of-Network
Ambulance Services	Plan pays 80% after deductible	Plan pays 80% after deductible
Pre-Admission Testing—Outpatient	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Ambulatory Surgery Facility	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Well Child Examinations and Immunizations	You pay a $20 copayment per visit; no deductible	Plan pays 60% of U&C after deductible
Limitations: *Ages 1 Week – 12 Months* *Ages 13 Months – 6 Years* *Ages 7 Years – 17 Years* *Ages Birth – 17 Years*	 *Six exams, including testing* *One exam, including testing, per Calendar Year* *One exam, including testing, every 5 Calendar Years* *Routine childhood immunizations*	
Adult Wellness Examinations (ages 18 and older)	You pay a $20 copayment per visit; no deductible	Plan pays 60% of U&C after deductible
Limitation: *Routine Exam*	 *One routine exam, including testing, every 2 Calendar Years, up to $250 per visit*	
Immunizations (non-routine)	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitations: *Pneumonia Immunization* *Flu Immunization*	 *One every 6 Calendar Years* *One per Calendar Year*	
Cervical Cancer Screening	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*One gynecology examination and pap test per Calendar Year for females age 18 and older*	
Breast Cancer Screening	Plan pays 80% after deductible	Plan pays 60% of U & C Charges after deductible
Limitations: *Females Ages 35 – 39* *Females Ages 40 and Older*	 *One baseline screening mammogram* *One screening mammogram per Calendar Year*	

Plan Feature	In-Network	Out-of-Network
Prostate Cancer Screening	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*One office visit and examination, including PSA test, per Calendar Year, for males ages 50 and older*	
Reconstructive Surgery (Medically Necessary)	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Breast Reconstruction after Mastectomy	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Blood Products and Transfusions	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Chemotherapy	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*$250 per person per lifetime for wigs, toupees or hairpieces to replace hair lost due to chemotherapy*	
Dialysis (Hemodialysis or Peritoneal Dialysis)	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Chiropractic/Spinal Manipulation Services	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*$1,000 per person per Calendar Year*	
Acupuncture Services	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*$500 per person per Calendar Year*	
Corrective Appliances (Prosthetic and Orthotic Devices)	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*$500 per person per Calendar Year for foot orthotic benefits*	
Durable Medical Equipment (DME)	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Hearing Aids - Basic Binaural Only	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*2 binaural basic hearing aids per person per 36 month period*	

Plan Feature	In-Network	Out-of-Network
Skilled Nursing Facility or Subacute Facility (pre-certification required)	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*60 days per person per Calendar Year*	
Home Health Care and Home Infusion Services	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*40 visits per person per Calendar Year*	
Hospice Care Services	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*$30,000 per person per lifetime*	
Mental Health and Substance Abuse Treatment (pre-certification required)	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitations: *Inpatient (precertification required):* *Outpatient:*	*Limited to 30 days per person per Calendar Year, including day treatment or partial day care. Combined maximum applies to both Mental Health and Substance Abuse Treatment.* *Limited to 40 visits per person per Calendar Year. Combined maximum applies to both Mental Health and Substance Abuse Treatment.*	
Maternity Services	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Sterilization Services (Vasectomy, Tubal Ligation)	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Oral and Craniofacial Surgery	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Physical and Speech Therapy, Pulmonary Rehabilitation Services	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitations:	*40 visits for physical therapy, speech therapy and pulmonary rehabilitation combined per person per Calendar Year* *20 visits for pulmonary rehabilitation per person per Calendar Year*	

Plan Feature	In-Network	Out-of-Network
Cardiac Rehabilitation	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitations:	*$5,000 per person per cardiac incident; limited to services provided during a 12-week period*	
Sleep Studies/Obstructive Sleep Apnea	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitation:	*$10,000 per person per lifetime*	
Organ/Tissue Transplants (requires pre-certification)		
Organ/Tissue Procurement	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Transplant Related Travel Expenses	Plan pays 80% after deductible	Plan pays 60% of U&C after deductible
Limitations: *All Transplant Related Services and Supplies* *Organ/Tissue Procurement* *Travel Expenses*	 *$1,000,000 per person per transplant* *$50,000 per person per transplant* *$10,000 per person, limited to $250 per day for lodging and meals*	
Donor Expenses Donor Covered under Plan Donor Not Covered under Plan	 Plan pays 100%; no deductible Plan pays 100T; no deductible	 Plan pays 60% of U&C after deductible Plan pays 100% of U&C; no deductible
Limitations:	*Expenses apply to the transplant recipient's lifetime maximum* *Expenses incurred by a donor who is not covered by this Plan are payable only to the extent the donor is not covered by his or her own insurance or health care plan*	

Covered Medical Services

To be covered under the Plan, services must be Medically Necessary with the exception of those listed as preventive care. Covered services are subject to applicable deductibles, exclusions and other conditions and limitations, as described in this SPD.

The Plan only pays up to the Usual and Customary charge for the following services and supplies covered under this Plan, when prescribed by the attending Physician for Illness, Injury, maternity or preventive care:

Hospital Services (Inpatient)

- Room and board facility fees in a semi-private room with general nursing services.
- Specialty care units (e.g., Intensive Care Unit, cardiac care unit).
- Laboratory, X-ray and diagnostic services.
- Related Medically Necessary ancillary services (e.g., prescription drugs administered while hospitalized, supplies).
- Newborn care (deductible applies to well newborn).
- Private room charges in excess of the semi-private room rate only if a private room is Medically Necessary or if the facility does not provide semi-private rooms.

Physician Services

- Professional services provided by a Physician in an office, Hospital, emergency room, urgent care facility or other covered health care facility. Primary care Physicians include internal medicine, family medicine, general practice, pediatric and OB/GYN. Specialists include any Physician not considered a primary care Physician.
- Assistant surgeon fees for Medically Necessary services, but only up to a maximum of 20% of the covered charges payable to the primary surgeon.
- Office visits with a Physician for second and third surgical opinions.
- Multiple surgical procedures. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan determines which surgical procedures are separate procedures and which are considered included as a single procedure for determining benefits. When the procedures are considered separate procedures, the following percentages of the Usual and Customary charge will be allowed as the Plan's benefit, subject to the Plan's coinsurance:
    - Allowances for multiple surgeries through the same incision or operational field: 100% of the Usual and Customary charge for the most costly procedure; no benefits for secondary and additional procedures.
    - Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session: 100% of the Usual and Customary charge for the most costly procedure, plus 50% of the Usual and Customary charge per procedure for the secondary and additional procedures.

Laboratory Services (Outpatient)

- Technical and professional fees for laboratory services ordered by a Physician.

Radiology, Nuclear Medicine and Radiation Therapy Services (Outpatient)

- Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.

Emergency Room Services

- Hospital emergency room facility services for a medical emergency.
- Ancillary services (such as laboratory or x-ray) performed at an emergency room visit.

Expenses for emergency room services are covered only when those services are for a medical emergency.

Emergency Situations: The Plan covers emergency care 24-hours-a-day; 7-days-a-week. For a life-threatening emergency, seek care immediately at the nearest emergency facility or call 911.

Ambulance Services

- Ground vehicle transportation to the nearest appropriate facility for treatment of a medical emergency, acute Illness or an inter-health care facility transfer.
- Air or sea transportation due to inaccessibility by ground transport, or if the use of ground transport would be detrimental to the patient's health status.

Expenses for ambulance services are covered only when those services are for a medical emergency. In addition, the ambulance service must be licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Preadmission Testing (Outpatient)

- Laboratory tests, x-rays and other tests performed on an outpatient basis before a scheduled Hospital admission or outpatient surgery.

Outpatient/Ambulatory Surgery Facility

- Outpatient/Ambulatory Surgical Facility services (e.g., surgicenter, same day surgery).

Reconstructive Surgery

- Reconstructive surgery if solely intended to improve bodily function or to correct deformity resulting from disease, infection, trauma or congenital anomaly that causes a functional defect.

Breast Reconstruction after Mastectomy

- In connection with a mastectomy and breast reconstruction, coverage is provided for:
  - Reconstruction of the breast on which the mastectomy was performed.
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  - Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

Blood Products/Transfusions

- Blood transfusions.
- Blood products and equipment for their administration.
- Expenses related to preoperative autologous blood donation (i.e., the patient's own blood), storage and transfusion; however, storage fees are limited to a maximum of 90 days.

Chemotherapy

- Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, health care facility, Physician's office or at home. Benefit payments may vary depending on the location in which the chemotherapy is delivered or received by the patient. For example, if the chemotherapy is delivered in a Hospital, it is reimbursed as a covered Hospital service; if the chemotherapy is delivered at home or in a Physician's office, it is reimbursed as a covered Physician service.
- A single wig, toupee or hairpiece if it is required to replace hair lost because of chemotherapy, up to the Plan's maximum.

Dialysis

- Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, health care facility, Physician's office or at home. Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received.

Chiropractic (Spinal Manipulation) Services

- Spinal manipulation services (from a Physician or chiropractor), including related ancillary services (e.g., office visits, x-rays, physical therapy, diagnostic tests), up to the Plan's maximum.

Acupuncture Services

- Acupuncture services up to the Plan's maximum, but only if the practitioner is licensed or duly authorized to practice in the jurisdiction in which the services are provided.

Corrective Appliances (Prosthetic and Orthotic Devices)

- Rental of prosthetic and orthotic devices, but only up to the allowed purchase price of the device.
- Purchase of the standard model of a prosthetic or orthotic device.

- Repair, adjustment or servicing of a prosthetic or orthotic device or replacement of the device due to a change in the Covered Person's physical condition or if the device cannot be satisfactorily repaired.
- Up to two pairs of anti-embolism or vascular support garments (e.g., Jobst) per Calendar Year.
- Foot orthotics (orthopedic or corrective shoes and other supportive appliances for the feet) once every 12 months for adults and once in a period of six months for children under age 19 when replacement is required due to growth, up to the Plan's maximum.
- One pair of eyeglasses or contact lenses after the surgical removal of the lens of the eye, such as with a cataract extraction.
- Up to four post-mastectomy replacement bras payable every 12 months. One replacement silicone breast prosthesis payable every 24 months. For fabric, foam or fiber-filled breast prostheses, replacements payable every six months. Replacements that are more frequent must be determined by the Plan to be Medically Necessary.

Durable Medical Equipment (DME)

- Rental of durable medical equipment up to the allowed purchase price of the durable medical equipment.
- Purchase of the standard model of durable medical equipment.
- Repair, adjustment, servicing or Medically Necessary replacement of the durable medical equipment.
- Durable medical equipment required due to a change in the person's physical condition or if the equipment cannot be satisfactorily repaired.
- Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration.

Hearing Aids - Basic Binaural Only

- Basic Binaural hearing aids, limited to two units per 36-month period.
- Related examinations, testing and dispensing fees are not covered.

Skilled Nursing Facility (SNF) or Subacute Facility

- Services and supplies ordered by a Physician and provided by a Skilled Nursing Facility (SNF) or subacute care facility, also called Long Term Acute Care (LTAC) facility.
- Skilled Nursing Facility Confinement or subacute care facility Confinement is payable up to the Plan's maximum.

Home Health Care and Home Infusion Services

- Part-time, intermittent skilled nursing care services and Medically Necessary supplies to provide Home Health Care or home infusion services, up to the Plan's maximum.
- Home Health Care and home infusion services ordered by a Physician and provided by a licensed Home Health Care Agency.
- Covered medications are provided through the Plan's prescription drug benefits.

- Home hospice care as hospice care services.
- Home physical therapy services as outpatient rehabilitation services.

Hospice Care Services

- Hospice care services, including inpatient hospice care and outpatient home hospice care, for terminally ill persons assessed to have a life expectancy of six months or less. Benefits for combined inpatient and outpatient hospice care are limited to the Plan's maximum.
- Up to two bereavement counseling sessions for the family.

Mental Health and Substance Abuse Treatment

- Inpatient treatment of Mental Health or Substance Abuse, including day treatment or partial day care (two days of day treatment or partial day care count as one inpatient Hospital day); up to the Plan's maximum.
- Outpatient treatment of Mental Health or Substance Abuse, up to the Plan's maximum.

Maternity Services

- Hospital and Physician fees for maternity services.
- Pregnancy-related care is covered for a female Retired Employee or Dependent Spouse only. No coverage is provided for maternity or delivery expenses of Dependent Children.
- This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section or requiring a Physician to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).
- Elective induced abortion when the attending Physician certifies that the female Retired Employee's or Dependent Spouse's health would be endangered if the fetus were carried to term or that the child will be born with significant congenital deformities or defects.

Circumcision

- Circumcision for newborn males from birth to 10 weeks of age, and thereafter, only if it is determined to be Medically Necessary.

Sterilization

- Male and female sterilization services (e.g., vasectomy, tubal ligation).

Infertility

- Charges for services to establish the initial diagnosis of infertility.

Medical Foods

- Medical foods for persons with inherited metabolic disorders, up to the Plan's maximum, provided the:
    - The patient requires specially processed or treated medical foods that must be consumed throughout his or her life without which the patient may suffer serious mental or physical impairment.
    - The patient is under the regular supervision of a Physician to monitor the inherited metabolic disorder.
- Documentation to substantiate the presence of an inherited metabolic disorder and that the products purchased are medical foods may be required before the Plan will reimburse the person for costs associated with this benefit.

Oral and Craniofacial Surgery

- Oral or craniofacial surgery to remove tumors and cysts, treat abscesses and treat certain accidental Injuries to the teeth and jaws:
    - The accidental Injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting).
    - The dental treatment paid will be the most cost-effective option that meets acceptable standards of professional dental practice.
    - The dental treatment is designed to return the person's teeth to their pre-Injury level of health and function.

Outpatient Rehabilitation Services (Physical and Speech Therapy)

- Short-term, active, progressive rehabilitation services (physical or speech therapy) performed by licensed or duly qualified therapists as ordered by a Physician.
- All outpatient physical therapy, outpatient speech therapy and pulmonary rehabilitation are subject to the Plan's combined visit limit.
- Outpatient physical therapy performed in conjunction with spinal manipulation services is subject to the Plan's limitations for spinal manipulation services.
- Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagic or swallowing defects and disorders lost due to Illness, Injury or surgical procedure.

Cardiac Rehabilitation Services

- Cardiac rehabilitation for a Participant who has had cardiac (heart) surgery or a heart attack, up to the Plan maximum.

Pulmonary Rehabilitation Services

- Pulmonary rehabilitation for a Covered Person with a chronic respiratory disorder who is able to actively participate in a pulmonary rehabilitation program that is likely to improve respiratory condition.
- All pulmonary rehabilitation, outpatient physical therapy and outpatient speech therapy is subject to the Plan's combined visit limit. In addition, benefits for pulmonary rehabilitation are limited to a specific Plan visit limit.

Sleep Studies/Obstructive Sleep Apnea

- Diagnostic sleep studies and treatment of documented obstructive sleep apnea, up to the Plan maximum.

Transplants (Organ and Tissue)

Transplant Candidates: You should request pre-certification as soon as you are identified as a potential transplant candidate. You will receive information about the Health Care Management program and be asked to enroll in the Program. Once enrolled, a transplant facilitator will be assigned to help coordinate your care with your Physician. The transplant facilitator will work with you and your Physician to ensure quality and continuity of care throughout the process, pre-transplant to post-transplant, including organ harvesting, Hospital selection, travel arrangements and prescription drug options,.

- Services directly related to the following non-Experimental transplants of human organs or tissue, including facility and professional services, FDA approved drugs and Medically Necessary equipment and supplies:
  - Bone marrow/peripheral blood stem cell.
  - Heart/lung.
  - Kidney.
  - Kidney/pancreas.
  - Liver.
  - Lung.
  - Pancreas.
- Organ/tissue procurement, up to the Plan maximum, which includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient. Transportation fees are only payable when the organ/tissue is transported within the United States.

- Reasonable and necessary medical expenses incurred by a donor who is:
  - A Covered Person, which are payable without any deductibles and coinsurance applicable to those expenses.
  - Not covered by this Plan, which are payable without any deductibles and coinsurance applicable to those expenses, but only to the extent the donor is not covered by the donor's own insurance or health care plan.
  - Donor expenses apply toward the covered transplant recipient's lifetime maximum.
- Transplant related travel expenses, including transportation, lodging and meals for the patient and one family member or companion, up to the Plan maximum. Reimbursement is available for round trip coach airfare and up to the Plan maximum for lodging and meals received during the pre-operative work-up, transplant operation and post-transplant treatment phases. Receipts are required when submitting lodging, meals and travel expenses. Covered expenses do **not** include car rental, telephone calls, personal care items such as shampoo, entertainment expenses, alcohol/tobacco, souvenirs or expenses for persons other than the patient and his/her designated family member/companion.
- The overall Plan maximum applies to transplant-related services and supplies (including donor harvesting expenses, organ or tissue procurement, surgery, acquisition fees, etc.) from the date of recipient work-up and organ acquisition through 18 months after transplant surgery.
- When determining benefits available per transplant, the following are considered single transplants:
  - Bone marrow/peripheral blood stem cell.
  - Heart/lung.
  - Kidney/pancreas.

Chelation Therapy

- Chelation therapy for treatment of acute arsenic, gold, mercury or lead poisoning or for diseases due to clearly demonstrated excess of copper or iron.

Well Child Examinations and Immunizations

- Six outpatient well child examinations, including testing, from age one week through 12 months.
- One well child examination, including testing, per Calendar Year from age 13 months through six years.
- One well child examination, including testing, every five Calendar Years from age seven years through 17 years.
- Routine childhood immunizations (e.g., DPT, Polio, MMR, HIB, hepatitis, chicken pox, tetanus) from birth through age 17 years.

Adult Wellness Examinations (Age 18 and Older)

- One routine preventive physical examination, including testing, every two Calendar Years, up to $250 per visit.
- One pneumococcal (pneumonia) immunization every six Calendar Years.
- One influenza (flu) immunization per Calendar Year.
- Cervical cancer screening and breast cancer screening for females:
  - One gynecology examination and pap test per Calendar Year for females age 18 and older.
  - One screening mammogram per Calendar Year, including interpretation of the mammogram, for females age 40 and older.
  - Additional pap tests and mammograms Medically Necessary due to a Covered Person's condition (subject to all applicable Plan provisions).
- Prostate cancer screening for males age 50 and older:
  - One office visit and digital rectal examination per Calendar Year, including a Prostate Specific Antigen (PSA) blood test.
  - Additional digital rectal examinations and Prostate Specific Antigen (PSA) blood tests that are Medically Necessary due to a Covered Person's condition (subject to all applicable Plan provisions).
- One colorectal cancer screening every two years for individuals age 18 and older, includes fecal occult blood tests, barium enema, sigmoidoscopy and colonoscopy.
- Bone density testing.

Medical Program Compliance

- **Primary Care Physician (PCP):** You may name any Provider who participates in the Anthem network as your PCP. While choosing a PCP is not required, a PCP can coordinate your overall health care. You may also name a pediatrician as the PCP for your child(ren).
- **Newborns' and Mothers' Health Protection Act:** The Plan does not restrict a mother's or newborn's benefits for a Hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The attending Provider (who may be a Physician or nurse-midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. The Plan will not, under federal law, require that a Provider obtain authorization from the Plan or the Claims Administrator for prescribing a length of stay of 48 hours or less for vaginal delivery (or 96 hours for cesarean section).

- **Women's Health and Cancer Rights Act:** The Plan provides mastectomy-related benefits to Plan participants. If you are a Covered Person who receives benefits for a mastectomy and decide to have breast reconstructive surgery, the Plan will provide coverage in a manner determined in consultation with the attending Physician and you for:
  - Reconstruction of the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce symmetrical appearances; and
  - Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

  These procedures will be covered the same as any other medical/surgical benefit under your Plan. Certain general coverage limitations may apply, including, but not limited to, deductibles, coinsurance, copayments and covered charges.

Medical Limitations and Exclusions

The following charges are not covered:

1. Expenses for an autopsy, except as required by the Plan.
2. Expenses for non-medical services, such as claim form preparation, shipping and handling fees, photocopying fees, prescription refill charges, late fees, etc.
3. Charges for broken/missed appointments.
4. Expenses that exceed any Plan benefit limitation or annual or lifetime Maximum Benefit.
5. Any portion of an expense that exceeds the Usual and Customary charge.
6. Expenses for services or supplies for which a third party is required to pay.
7. Expenses incurred before being covered under the Plan or after coverage ends.
8. Expenses for medical services or supplies determined by the Plan to be Experimental or Investigational.
9. Expenses for services for which benefits are provided under any plan or program established under the laws or regulations of any government, unless the governmental program provides otherwise.
10. Expenses incurred for Injuries resulting from or sustained due to commission (or attempted commission) of a felony, other than due to an act of domestic violence.
11. Services or supplies determined by the Plan not to be Medically Necessary.
12. Expenses for construction or modification to a home, residence or vehicle, including construction of ramps, handrails, chair lifts, hot tubs, air filtration, swimming pools, etc.
13. Expenses that a person is not required to pay or for which there would be no charge if the person were not covered under this Plan.

14. Expenses for services and supplies not recommended or prescribed by a Physician.

15. Expenses for and related to non-emergency travel or transportation (including lodging, meals, and related expenses), unless the expenses are related to a Plan approved transplant.

16. Expenses arising out of or in the course of employment (including self-employment) if the Illness or Injury is subject to coverage, in whole or in part, under workers' compensation or occupational disease or similar law. This applies even if the person is not covered by workers' compensation.

17. Expenses for patient convenience, including, but not limited to, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, etc.

18. Expenses for physical examinations and testing required for employment, government purposes, insurance, school, camp, recreation, sports or by any third party.

19. The use of a private room in a Hospital or other health care facility, unless the facility has only private room accommodations or the use of a private room is Medically Necessary.

20. Expenses for services provided by the parent, spouse, sibling (by birth or marriage) or child of the Covered Person.

21. Expenses for the services of a medical student, intern or resident.

22. Expenses for a Physician who did not directly provide or supervise medical services, even if the Physician was available on a stand-by basis.

23. Expenses for medical services or supplies rendered or provided outside the United States, including expenses associated with return travel to the United States, except for treatment of a medical emergency, while traveling outside the United States. Coverage for any medical emergency is only provided if the patient can be stabilized and/or returned to the United States for continuing follow-up treatment.

24. Expenses for telephone calls between a Physician and patient, other health care Provider, utilization review company or Plan representative.

25. Expenses incurred from an Illness or Injury due to an act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion or invasion, except as required by law.

26. Expenses related to complications of a non-covered service.

27. Expenses for acupuncture unless provided by:

    a. A Physician (MD or DO) with proper credentials to perform acupuncture in the state in which he or she is licensed.

    b. An acupuncturist who is licensed in the state in which he or she is practicing or, certified by the National Certification Commission for Acupuncturists (NCCA) if licensing is not required.

28. Expenses for acupressure.

29. Expenses for chelation therapy, except when Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning and for diseases due to clearly demonstrated excess of copper or iron.

30. Expenses for residential care services for treatment of mental disorders.

31. Expenses for hypnosis, hypnotherapy and biofeedback.

32. Expenses for services related to:
    a. Dyslexia, learning disorders and educational delays, including tests and related expenses to determine the presence or degree of such condition.
    b. Court-ordered Mental Health care services or custody counseling.
    c. Marriage/couples counseling.

33. Expenses for items that do not meet the Plan's definition of durable medical equipment, orthotic device or prosthetic appliance, including air purifiers, saunas, escalators, lifts, motorized modes of transportation, air conditioners, etc.

34. Expenses for replacement of lost, missing or stolen durable medical equipment, orthotic devices and prosthetic appliances.

35. Expenses for the purchase of durable medical equipment, orthotic devices and prosthetic appliances in excess of the cost of standard models of such equipment.

36. Expenses for the rental of durable medical equipment, orthotic devices and prosthetic appliances in excess of the purchase price of such equipment.

37. Expenses for occupational therapy, adaptive supplies and devices used to assist a person in performing activities of daily living, including feeding utensils, reaching tools, devices to assist in dressing and undressing, raised toilet seats, etc.

38. Expenses for supplies that are considered disposable and limited to use by a single person or one-time use, including bandages, hypodermic syringes, diapers, soap, cleansing solutions, etc.

39. Expenses for cosmetic surgery or treatment to improve or preserve physical appearance, but not physical function, including, but not limited to, breast augmentation, tummy-tucks, treatment of varicose veins, etc. However, the Plan does cover Medically Necessary reconstructive services.

40. Expenses for Custodial Care.

41. Expenses for dental services or supplies, including dental prosthetics, the care, filling, removal or replacement of teeth and the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. Expenses for dental services may be covered if they are incurred for the repair or replacement of accidental Injury to teeth or restoration of the jaw if damaged by an external object in an accident. For this coverage, an accident does not include any Injury caused by biting or chewing.

42. Expenses for the diagnosis, treatment or prevention of Temporomandibular Joint (TMJ) dysfunction or syndrome.

43. Expenses for oral surgery to remove teeth, gingivectomies and root canals, except that coverage is provided for oral surgery to remove tumors, cysts and abscesses.

44. Expenses for foods and nutritional supplements, including formulas, diet foods, vitamins, herbs and minerals (even if they require a prescription), except foods and nutritional supplements provided during covered hospitalization.

45. Expenses for medical foods, unless prescribed to treat an inherited metabolic disorder for which the patient is under the regular supervision of a Physician.

46. Expenses for take-home drugs or medicines provided by a Hospital or other health care facility.

47. Expenses for vaccinations and immunizations, unless required for the treatment of an Injury or because of exposure to disease/infection (such as anti-rabies, or tetanus).

48. Expenses for services and supplies to induce pregnancy (and complications thereof), including in vitro fertilization, artificial insemination, reversal of sterilization, etc.

49. Expenses for routine foot care.

50. Expenses for genetic tests and counseling.

51. Expenses for hair removal or hair transplants, except that the Plan will provide benefits for a single wig, toupee or hairpiece required to replace hair lost because of chemotherapy, up to the amount covered by the Plan.

52. Expenses for and related to hearing aid devices, including, cochlear implants, unless otherwise specified by the Plan.

53. Expenses for any Home Health Care services other than part-time, intermittent skilled nursing services and supplies, except when Home Health Aides Services are covered under Home Health Care services.

54. Expenses related to prevention of pregnancy, including, but not limited to contraceptive devices such as condoms, Intra-Uterine Devices (IUD), diaphragms and implantable birth control devices.

55. Expenses for elective induced abortion, unless the attending Physician certifies that the health of the woman would be endangered if the fetus were carried to term or that the child will be born with significant congenital deformity or defect.

56. Expenses for childbirth education, Lamaze classes and breast-feeding classes.

57. Expenses related to the maternity care and delivery expenses associated with a Dependent Child’s pregnancy.

58. Expenses for treatment of infertility and fertility enhancements, including in vitro fertilization, artificial insemination or any other artificial means of conception.

59. Expenses for services of private duty nurses.

60. Expenses for job training and educational or vocational rehabilitation.

61. Expenses for massage therapy.

62. Expenses incurred for inpatient rehabilitation for an individual who is comatose or otherwise incapable of conscious participation in the therapy.

63. Expenses for maintenance rehabilitation. Maintenance rehabilitation refers to therapy provided after active rehabilitation where no continued significant improvement is expected.

64. Expenses for speech therapy to treat speech impediments, stuttering, lisping, stammering, etc.

65. Expenses for treatment of delays in childhood speech development, unless due to an Injury or surgery.

66. Expenses for injection of sclerosing solutions into joints, muscles or ligaments.

67. Expenses for treatment of erectile dysfunction.

68. Expenses for treatment related to gender reassignment (sex change) procedures.

69. Expenses related to the treatment of sleep disorders or snoring, except that coverage is provided for diagnostic sleep studies and for treatment of documented obstructive sleep apnea, up to the maximum covered by the Plan.

70. Expenses related to non-human (xenografted) organ/tissue transplants, except heart valves.

71. Donor expenses, unless the person who receives the donated organ/tissue is a Covered Person, but only if donor expenses are not covered under the donor's health coverage.

72. Expenses for Radial Keratotomy (RK), Automated Keratoplasty (AK), Laser In-Situ Keratomileusis (LASIK) and similar procedures or for implantable contact lenses.

73. Expenses for eye examinations, eyeglasses and contact lenses, except one pair of eyeglasses or contact lenses are payable following ocular surgery to remove the lens of the eye.

74. Expenses for vision therapy (orthoptics) and supplies.

75. Expenses for medical or surgical treatment of obesity, including gastric bypass, bariatric surgery, weight loss programs, etc., even if treatment is for a co-morbid or underlying health condition.

76. Expenses for health club memberships, physical fitness programs and exercise equipment.

77. Expenses for allergy sensitivity treatment and allergy antigen solution.

78. Expenses arising from a self-inflicted Injury or Illness, including complications thereof. However, expenses are not excluded if the Illness or Injury is due to an act of domestic violence or arises from a physical or Mental Health condition.

Prescription Drug Benefits

If you need to locate a participating pharmacy, use the mail order program or determine if a particular prescription is a brand name or maintenance medication, contact CVS Caremark:

– By phone at (800) 841-5550; or

– Online at www.cvscaremark.com.

The Plan provides prescription drug coverage for you and your eligible dependents. These benefits can play an important role in your overall health. Prescription drug benefits are administered by CVS Caremark, which offers a:

- Retail pharmacy program, for your short-term medication needs; and
- Mail order program, for maintenance (long-term) medications.

Prescription Drug Copayment

If your medication is covered by the Plan, you pay a portion of the cost and the Plan pays the rest. The portion you pay is known as a copayment, which varies based on the category of medication and the day supply, as described in the following sections.

It is to your benefit to ask your Physician if there is a generic equivalent for any medication prescribed and if it would be appropriate for you instead of the brand name medication. You pay more when you have your prescription filled with a brand name medication.

Participating Retail Pharmacy Program

CVS Caremark has a national network of participating pharmacies. To have your prescription filled, for up to a one-month supply:

- Bring your prescription to a participating pharmacy;
- Show your CVS Caremark ID card to the pharmacist; and
- Pay your copayment.

Your copayment, per one-month supply of your prescription, is:

- $5 per for a generic medication;
- $30 for a formulary (single source, no generic available) brand name medication; or
- $80 for a non-formulary (multi-source, generic available) brand name medication.

You will receive a CVS Caremark ID card, which you and your eligible dependents must present whenever you fill a prescription. If you lose your CVS Caremark ID card, you may request a replacement by contacting CVS Caremark.

In most cases, you will find a participating pharmacy available to meet your prescription needs. However, if you are unable to locate a participating pharmacy, send your prescription to:

CVS Caremark
P.O. Box 853901
Richardson, Texas 75085-3901

Mail Order Program

CVS Caremark provides a convenient and cost-effective way for you to order up to a three-month or 90-day supply of your long-term or maintenance medication at one time – and you can have your prescription delivered directly to your home. A maintenance medication is any prescription medication that is taken on a long-term basis for chronic conditions, such as asthma, diabetes, high cholesterol, high blood pressure or arthritis.

Contact CVS Caremark for specific information on how to use the mail order program. Follow the instructions in written materials you receive or that you can get on the CVS Caremark website. For new medications, you may want to ask your Physician to write two prescriptions:

- One for up to a 90-day supply, plus refills, to be ordered through the mail order program; and
- One for up to a one-month supply, to be filled immediately at a participating retail pharmacy (for use until you receive your prescription order from the mail order program).

Your copayment, per three-month/90-day supply of your prescription, is:

- $10 per for a generic medication;
- $60 for a formulary (single source, no generic available) brand name medication; or
- $170 for a non-formulary (multi-source, generic available) brand name medication.

Cost Saving Programs

To help you get the most of your benefits, this coverage includes the following cost saving programs:

- **Generic Incentive:** Many prescription medications are available under more than one name; a generic name and a brand name. By law, both generic and brand name medications must meet the same standards for safety, purity and effectiveness. A generic usually serves the same purpose but it is simply a brand name medication that is no longer protected by a patent, which means it generally costs less. To encourage you to use generics whenever possible, your copayment is lowest when you have your prescription filled with a generic medication.
- **Prior Authorization:** Some medications require CVS Caremark to conduct a clinical review before the medication will be covered. Examples include weight-loss, Attention Deficit and Hyperactivity Disorder (ADHD) and biotech/specialty drugs.
- **Specialty Drugs:** The Plan also has a special program for clinical review and management of use of certain specialty drugs, called the Specialty Guideline Management (SGM) Program. Contact BeneSys or CVS Caremark for more information.

- **Quantity Limits:** For most medications, the Plan covers a one-month supply of medication at a retail pharmacy or a three-month supply through the mail order program. However, for certain medications, such as drugs used to treat migraines, erectile dysfunction and certain inhaler medications, the Plan imposes lower quantity limits. Quantity limits are lower for medications that:
  - The FDA has approved only for short-term use;
  - May be less effective or harmful when overused;
  - Are frequently over-utilized.
- **Limited Retail Refills on Maintenance Medications:** You may choose to fill a prescription for a maintenance medication up to two times at any participating retail pharmacy. After the second fill, you will be responsible for the full cost of your third prescription if you have your prescription filled at a retail pharmacy.

Covered Prescription Drug Expenses

The Plan covers the following kinds of prescription drugs, subject to your copayment:

- Federal legend drugs;
- Compounded medication of which at least one ingredient is a prescription legend drug;
- Insulin;
- Insulin syringes and needles on prescription (charges for other diabetic supplies may be covered under your medical benefits); and
- Legend and non-legend prescription Meclizine.

Over the Counter Medications

Prescription drug benefits cover only medications that are prescribed by a health care professional. However, over the counter medications are often less costly than Physician prescribed medicines and many are lower strength versions of prescription drug that meet higher safety standards for self-medication. Check with your health care professional to see if over the counter medications are a viable treatment option.

Coordination of Benefits

The Plan's coordination of benefits provision does not apply to prescription drug benefits. The Plan is the primary payor of prescription drug benefits.

Prescription Drug Limitations and Exclusions

The following charges are not covered:

1. Any prescription dispensed before your effective date or after the termination date of coverage.

2. Charges for the administration or injection of any drug.

3. Refills of covered drugs that exceed the number that the prescription order specifies or refills of covered drugs after one year from the date of the original prescription.

4. Covered prescription drugs that are not customarily charged for, or for which the Provider's charge is less than the required copayment.

5. Claims arising out of, or in any course of any occupation or employment for wage or profit or Claims for which you are entitled to benefits under any workers' compensation or occupational disease law, whether benefits are claimed or not.

6. Charges furnished or covered by, or on behalf of, the United States, or any state, province or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance.

7. Charges incurred for which you are not, in the absence of this coverage, legally obligated to pay or for which a charge would not ordinarily be made in the absence of this coverage.

8. Covered prescription drugs or medicines covered by Medicare, if you are covered by or are eligible to be covered by either, Part A or B of Medicare, but only to the extent benefits are, or would be, available if you had applied for Medicare.

9. Charges incurred due to an Illness or Injury resulting from war, declared or undeclared, and/or armed aggression by the military forces of any country or combination of countries or any act incident to war.

10. Prescription drugs or medications that are Experimental or Investigational.

11. Prescription drugs or medicines in connection with sex transformation surgery, including sex hormones related to such surgery and prescription drugs or medicines in connection with treatment of sexual dysfunction not related to organic disease.

12. Prescription drugs or medicines for infertility, artificial insemination, in vitro or in vivo fertilization of an ovum, including Pergonal (Menotropins).

13. Non-legend drugs, other than Insulin and Meclizine.

14. Therapeutic devices or appliances, including support garments and other non-medicinal substances, unless specifically listed as covered.

15. Topical Minoxidil preparations, whether commercially prepared or compounded.

16. Anorectic drugs, used for the treatment of obesity.

17. All drugs that are not self-administered or are administered in a Hospital, long-term care facility or other inpatient setting.

18. Implantable contraceptives, such as Norplant, regardless of intended use.

19. Smoking deterrents.

20. Human growth hormones.

21. Contraceptive devices, unless determined to be Medically Necessary for a non-contraceptive purpose.

22. Prescription drugs and medicines used in connection with, or for subsequent treatment of, transplants of body parts, tissues or substances, or implants of artificial or natural organs.

23. Charges for Interferon beta-1b (Betaseron) and Avonex.

24. Proton Pump Inhibitors (PPIs).

Coordination of Benefits

Coordination of Benefits (COB) applies if you or a dependent are covered by more than one health plan. If coverage is provided under two or more plans, COB determines which plan pays first (is primary) and which plan is secondary. The plan considered primary pays its benefits first, without regard to benefits paid by any other plan. Any remaining expenses may be paid under the other plan(s), which is considered secondary. Benefits paid by all plans will not exceed the Allowable Expense and no plan pays more than it would without this coordination of benefits provision.

Another plan may include health care benefits or services provided by this Plan or:

- A group, blanket or franchise insurance coverage;
- A group practice and other group prepayment coverage;
- Any coverage under labor-management trusted plans, union welfare plans, employer organization plans or employee benefit organization plans;
- Any coverage under governmental programs, such as, but not limited to, Medicare, and any coverage required or provided by any statute;
- Individual automobile no-fault and traditional auto insurance;
- Individual or family insurance;
- Subscriber contracts;
- Individual or family coverage through Health Maintenance Organizations (HMO);
- Limited service organizations or any other prepayment;
- Student accident insurance provided through or by an educational institution; or
- Group practice or individual practice plan.

Determining Which Plan is Primary

When this Plan and another plan(s) cover you or another family member for the same covered expense, then the COB order of benefit determination rules will determine which plan pays first. If this Plan pays first then it is the Primary Plan and it will pay the full amount of the Plan benefit. If another plan pays first, this Plan will be the Secondary Plan and it will review any remaining balance to see if additional benefits are payable after the Primary Plan has paid. If any amount is payable by this Plan, the total amount paid by both plans will not exceed 100% of the benefit payable under this Plan.

Order of Benefit Determination Rules

If you or a dependent are covered by two or more plans, the order of benefit determination follows the rules below in this order:

- If the other plan does not have coordination of benefits provisions, that plan pays first.
- The benefits of a plan that covers an individual as an employee, member or subscriber (other than as a dependent) are determined before the benefits of a plan that covers the individual as a dependent.
- **Birthday Rule:** The benefits of a plan that covers the person as a dependent are determined according to which parent's birth date occurs first in a Calendar Year (day and month).
    - If the birth dates of both parents are the same, the plan that has covered the person for the longer period will be determined first.
    - If the other plan does not contain the birthday rule but has a rule that coordinates benefits based on gender and the plans do not agree on the order of benefit, the rule in the other plan will determine the order of benefits.
    - If two or more plans cover a person as a Dependent Child of divorced or separated parents, benefits for the dependent are determined in this order:
        - If there is a court decree that establishes financial responsibility for the child's health care expenses, the benefits of the plan that covers the child as a dependent of the parent with financial responsibility are determined before the benefits of any other plan that covers the child as a dependent.
        - If there is no court decree, the parents are separated or divorced and the parent with physical custody of the child has not remarried, then the benefits of the plan that covers the child as a dependent of the parent with custody is primary.
        - If there is no court decree, the parents are divorced and the parent with physical custody of the child has remarried, the benefits of the plan that covers the child as a dependent of the parent with custody are determined first, then the benefits of the plan that covers the child as a dependent of the stepparent and then the benefits of the plan that covers that child as a dependent of the parent without custody.
- The benefits of a plan that covers an individual through his or her own present employment or through the present employment of another person are determined before the benefits of a plan that covers the person as a laid-off or retired employee, or as a dependent of such person.
- If the above rules do not establish an order of benefits determination, the benefits of a plan that has covered the person for the longer period are determined before the benefits of a plan that has covered the person for the shorter period.

Coordination with No-Fault Auto Insurance

Where covered expenses are payable by a no-fault automobile insurer or other automobile insurer that pays without regard to fault, this Plan will always be the Secondary Plan.

Coordination with TRICARE/CHAMPUS

TRICARE is the health care program serving uniformed service members, retirees and their families. If you or your dependent are eligible for TRICARE coverage (formerly known as CHAMPUS or the Civilian Health and Medical Program, TRICARE will be the Secondary Plan.

Coordination with Medicaid

This Plan's benefits will be paid in accordance with any assignment of rights made by, or on behalf of, a Covered Person as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (Medicaid). The fact that an individual is eligible for or is provided medical assistance under Medicaid will not be taken into account when determining eligibility or payment of benefits. When this Plan has a legal liability to make payment, the Plan will make payment for benefits in accordance with any state laws.

Coordination with Medicare

This Plan complies with the rules of the Social Security Act of 1965, as amended. This means that if Medicare rules determine Medicare is the Secondary Plan, this Plan is primary. In all other cases, Medicare is primary and pays first.

Note: If any eligible medical expenses are paid by an individual Medicare plan, no payment will be made by this Plan.

When the Plan Needs to Coordinate Information

This Plan may need to disclose certain information to coordinate benefits with other another plan. To obtain the needed information, this Plan, without your consent, may release to, or obtain from, any insurance company, organization or person, the necessary information. You will be expected to provide any information required for this purpose.

Facility of Payment

Payment made under any other plan that, according to these provisions, should have been made by this Plan, will be adjusted. This Plan may pay to the organization that made a payment the amount that is determined to be payable. Any amount paid is considered a benefit paid under this Plan.

Claims and Appeals

Eligibility Claims and Appeals

BeneSys makes initial determinations regarding the eligibility, continued eligibility and termination of eligibility for Plan coverage. If BeneSys determines that you or a covered dependent are not eligible, you will receive written notice of the determination within 10 days. The notice will include:

- The specific reason or reasons for the denial;
- Specific references to pertinent Plan provisions on which the denial is based; and
- Information on any new or additional evidence considered, relied on or generated by the review process.

If you disagree with an eligibility determination, you or your authorized representative may appeal in writing to the Committee within 180 days after you receive notification of the determination.

The Committee's decision on appeal is final; there are no further appeals for the Committee's (or the designated subcommittee's) decision.

Medical Claims and Appeals

You should carry your medical ID card with you at all times, and present it when you go to your Physician, Hospital, clinic or other medical care Provider. Generally, the Provider will submit your Claim to as indicated on your ID card. However, how the Claim is paid may vary depending on if you use an in-network or out-of-network Provider, as follows:

- **In-Network Provider:** If you receive treatment or services from an in-network Provider, then the in-network Provider will file a Claim for you and payment will be made directly to that Provider.
- **Out-of-Network Provider:**
    - If you receive treatment or services from an out-of-network Provider, the Provider may file a Claim for you, in which case, payment may be made directly to the Provider.
    - If your Provider does not file the Claim for you or does not have an agreement with the network, payment will be made directly to you and you will be responsible for paying your Provider.

Filing a Medical Claim

If you need to file a Claim yourself, contact your medical carrier at the toll-free customer service number on the back of your medical ID card.

If your Plan benefit is subject to coordination of benefits, you may need to submit a copy of the other plan's Explanation of Benefits with your Claim if the other plan is primary. You can do this either when the Claim is initially submitted or as soon as possible afterward.

Time Limit for Filing a Medical Claim

You or your Provider must file your Claim within six months after the date of service or treatment or receipt of supplies. Your Claim will not be invalidated or reduced if it is not reasonably possible to provide written proof of the Claim within this period. However, no Claim is eligible for payment if it is filed more than 12 months from the date the Claim was incurred.

Medical Claim Determinations

The time for processing your Claim depends on what type of Claim it is, as follows:

- **Urgent Care Claims:**
  - An urgent care Claim is any Claim for medical care or treatment where using the regular time-frame for processing the Claim either:
    - Could seriously jeopardize your life or health or ability to regain maximum function; or
    - Would, in the opinion of a Physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.
  - If your Claim is an urgent care Claim for which pre-certification is required, you will be notified as soon as possible, taking into account the medical situation. A determination will be sent to you no later than 72 hours after your Claim is received.
  - If you or your Provider does not provide sufficient information to allow a determination on your urgent care Claim, you will be notified as soon as possible, but not later than 24 hours after the Claim is received. You will have a reasonable period (not less than 48 hours) to respond. After the additional information is received, you will be notified as soon as possible as to whether the Claim is granted or denied.
  - If you do not follow procedures for filing your urgent care Claim, you will be notified as soon as possible, but no later than 24 hours. You may be notified by telephone, unless you specifically request that it be in writing.
- **Concurrent Care Claims:**
  - A concurrent care Claim is one that is reviewed and possibly changed after a specified period. Usually this occurs if you are receiving ongoing treatment or the treatment is provided over a number of sessions.
  - You will be given notice of any reduction or termination in your benefits sufficiently in advance to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.
  - If you request to extend the course of treatment beyond the period or number of treatments in your initial Claim, your request will be decided as soon as possible taking into account the medical situation. You will receive notice of the determination within 24 hours after receipt of the request, as long as the request is received at least 24 hours before the end of the prescribed period or number of treatments.

- **Pre-Certification Claims:**
  - A pre-certification Claim is where the Plan requires you to obtain approval before you receive medical care, treatment or supplies.
  - You will be notified of a decision within a reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt of the Claim.
  - The 15-day period may be extended for an additional 15 days due to circumstances beyond the Plan's control. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which a decision is expected.
  - If you do not follow procedures for filing your pre-certification Claim, you will be notified as soon as possible, but no later than five days. You may be notified by telephone, unless you specifically request that it be in writing.
- **Post-Service Claims:**
  - A post-service Claim is any Claim that is not one of the types of Claims discussed above.
  - You will be notified of a decision within a reasonable period, but not later than 30 days after receipt of the Claim.
  - The 30-day period may be extended for an additional 15 days due to circumstances beyond the Plan's control. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which a decision is expected.

Appeal Procedures

If your Claim is denied, in whole or in part, you will be provided with a written or electronic notification, which will include all legally required information.

You, or your authorized representative, have the right to appeal an adverse benefit determination. You must file any appeal within 180 days after you received notice of a denial on your Claim. To file an appeal:

- **Urgent Care Claims:** You can appeal by telephone, using the customer service number listed on your medical ID card. All necessary information, including the benefit determination on review, will be transmitted to you by telephone, facsimile or by another similar method.
- **All Other Claims:** You can call the toll-free customer service number on your medical ID card for information on filing all other appeals, or you can submit an appeal in writing to:
  Anthem
  Attn: Appeals
  P.O. Box 33200
  Louisville, Kentucky 40232-3200

There are many protections for you in the Plan's appeal procedure. The appeal procedure:

- Provides you or your authorized representative the opportunity to submit written comments, documents, records and other information relating to your Claim.
- Allows you or your authorized representative to be given, upon request and free of charge, reasonable access to or copies of all documents, records and other information relevant to your Claim.
- Requires that all relevant comments, documents, records and other information submitted in the appeal, regardless of whether such information was submitted or considered in the initial benefit determination, be taken into account.
- Gives you 180 days following receipt of a notification of an adverse benefit determination to appeal the initial adverse determination and 180 days following receipt of the first appeal determination to request a final appeal.
- Requires that no deference will be given to the initial adverse benefit determination and requires that the review on appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual.
- Requires that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment (for example, a determination with regard to whether a particular treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate), the person(s) deciding the appeal consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- Identifies any medical or vocational experts whom the Plan consulted in connection with the denial of your Claim (even if their advice was not relied upon in denying the Claim), and requires that they not have been consulted in connection with the initial Claim denial.

Appeal Determinations

- **Urgent Care Claims:** You will be notified of the decision on review as soon as possible, taking into account the medical situation, but no later than 72 hours after receipt of your appeal.
- **Pre-Service Claims:** You will be notified of the decision on review within a reasonable time appropriate to your medical circumstances, but no later than 15 days after receipt of your appeal.
- **Post-Service Claims:** You will be notified of the decision within a reasonable time, but no later than 30 days after receipt of your appeal.

Final Committee Appeal

If your Claim is denied on appeal, in whole or in part, you or your authorized representative may submit a final appeal, in writing, to the Committee within 180 days after you receive notification of the denial. The final written appeal should be directed to the Fund Administrator at:

BeneSys, Inc. (Appeals)
P.O. Box 1708
Troy, Michigan 48099-1708

The Committee (or a subcommittee of Committee members) will process and decide the appeal and notify you or your authorized representative of the decision in writing in accordance with the requirements of all applicable and effective laws and regulations. The Committee's decision is the final level of appeal under the Plan and there are no further appeals from the Committee's (or the designated subcommittee's) decision.

Prescription Drug Claims and Appeals

Initial prescription drug determinations are made by CVS Caremark. If CVS Caremark denies coverage, in whole or in part, you, your Provider or your authorized representative can appeal the decision to the Fund Administrator. Your appeal should be in writing and mailed to:

BeneSys, Inc. (Appeals)
P.O. Box 1708
Troy, Michigan 48099-1708

Time Limit for Filing an Appeal

Your appeal must be received by BeneSys no later than 180 days after you received notice of CVS Caremark's denial of your prescription drug Claim.

If your Claim is denied, in whole or in part, you will be provided with a written or electronic notice, which will include all legally required information. The notice will include:

- The specific reason or reasons for the denial;
- Specific references to pertinent Plan provisions on which the denial is based; and
- Information on any new or additional evidence considered, relied on or generated by the review process.

Final Committee Appeal

If your Claim is denied on appeal, in whole or in part, you or your authorized representative may submit a final appeal, in writing, to the Committee within 180 days after you receive notification of the denial. The final written appeal should be directed to the Fund Administrator at:

BeneSys, Inc. (Appeals)
P.O. Box 1708
Troy, Michigan 48099-1708

The Committee (or a subcommittee of Committee members) will process and decide the appeal and notify you or your authorized representative of the decision in writing in accordance with the requirements of all applicable and effective laws and regulations.

The Committee's decision on appeal is final; there are no further appeals for the Committee's (or the designated subcommittee's) decision.

Physical Examination

The Plan has the right to have you examined, at the Plan's expense, for evaluation and verification of an Illness or Injury as often as required while a Claim for benefits is pending.

Plan's Right to Recover Overpayments or Improper Payments

The Plan has the right to recover payments made that exceed the maximum amount required under the Plan. You may be asked to reimburse the Plan for any Plan benefit payment that is later determined to be in excess of the amount required to be paid by the terms of the Plan. In addition, the Plan may reduce future benefits to recover these amounts. The Plan's right of recovery applies against any person to whom, for whom or with respect to whom such payments were made, or against any insurance companies or other organizations, which according to these provisions, provide benefits for the same Allowable Expense under any other plan.

If you make a material misrepresentation on your application for coverage, the Plan has the right to rescind (retroactively terminate) coverage. A material misrepresentation is an untrue statement that leads the Plan to cover the person or to cover a medical condition of the person when it would not have done so if it had known the truth. For example, if it is determined that an individual has enrolled an ineligible dependent in the Plan, that would constitute an intentional misrepresentation of a material fact and could result in a retroactive termination of that ineligible dependent's coverage. Rescinding coverage means the Plan can cancel coverage effective on the date coverage was granted in reliance on the material misrepresentation. The Plan will provide at least 30 days advance written notice to each participant who would be affected before coverage is rescinded. A retroactive termination is not a rescission to the extent it is attributable to a failure to timely pay required premiums or contributions for the cost of coverage. The Plan will refund all contributions paid for any coverage rescinded; however, Claims paid will be offset from this amount. The Plan reserves the right to recover from the Covered Person or Provider the amount paid on Claims incurred during the period for which coverage is rescinded.

Claims Administrator and Committee Discretion

The Claims Administrator has the sole and exclusive authority and discretion to interpret and to apply the rules of the Plan and the Committee has sole and exclusive authority and discretion to interpret and apply the rules of the Trust and other rules and regulations of the Trust. Under the law, this authority means that the Claims Administrator's and/or Committee's decision, or that of their designee, will be upheld unless the court finds that it was arbitrary and capricious. No action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under the terms of the Plan, any lawsuit brought against the Trust, the Committee, any of the Committee members individually, or any agent of any of these under or relating to the Plan, including the Fund Administrator and Claims Administrators, is barred unless the complaint is filed within three years after the right of action accrues, unless a shorter period is established by applicable statute, regulation or case law. You should seek legal advice with respect to these requirements.

Notice of Trust's Privacy Practices

This section describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully and contact the Plan's Privacy Officer if you have any questions.

The Plan is required by the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 to make sure that health information that identifies you is kept private to the extent required by law. This notice gives you information regarding the uses and disclosures of health information that may be made by the Plan and your rights and the Plan's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA. Please be advised, carriers associated with this Plan may issue separate Notices regarding disclosure of health information that they maintain on the Plan's behalf.

The Plan Privacy Officer can be contacted at:

UAW Retirees of the Dana Corporation Health & Welfare Trust
P.O. Box 1708
Troy, Michigan 48099-1708

How the Plan May Use and Disclose Health Information

The following categories describe different ways that the Plan uses and discloses health information. Not every use or disclosure in a category will be listed. However, all of the ways permitted to use and disclose information will fall within one of the categories.

- **For Payment.** The Plan may use and disclose health information to determine eligibility for Plan benefits, facilitate payment for the treatment and services received from health care Providers, determine benefit responsibility under the Plan or coordinate Plan coverage. For example, the Plan may tell a health care Provider about eligibility for benefits to confirm whether payment will be made for a particular service. The Plan may also share health information with a utilization review or pre-certification service Provider. Likewise, the Plan may share health information with another entity to assist with the coordination of benefit payments.
- **For Health Care Operations.** The Plan may use and disclose health information for Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use health information in connection with:
    - Conducting quality assessment and improvement activities;
    - Underwriting, premium rating and other activities relating to Plan coverage;
    - Reviewing and responding to appeals;
    - Conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; and
    - General Plan administrative activities.

- **To Inform You of Treatment Alternatives or Other Health Related Benefits.** The Plan may use health information to identify if you may benefit from communications from the Plan regarding:
    - Available Provider networks or available Plan products or services;
    - Your treatment;
    - Case management or care coordination; or
    - Recommended alternative treatments, therapies, health care Providers or settings of care. For instance, the Plan may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.
- **Use by the Trust Committee.** The Committee may use health information for plan administration functions, including but not limited to reviewing appeals; however, every effort is made to minimize the disclosure of personal medical information. Summary health information may be used for soliciting premium bids from health insurers or for consideration in decisions whether to modify, amend or terminate the Plan. The Committee also may have access to information on whether you are participating in the Trust.
- **When Legally Required.** The Plan will disclose health information when it is required to do so by any federal, state or local law.
- **For Public Health Activities.** The Plan may disclose health information for public health activities such as the reporting of vital events, such as birth or death or the tracking of products regulated by the Food and Drug Administration.
- **To Conduct Health Oversight Activities.** The Plan may disclose health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. However, we may not disclose health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.
- **In Connection with Judicial and Administrative Proceedings.** As permitted or required by state law, the Plan may disclose health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan receives satisfactory assurance from the party seeking the information that reasonable efforts have been made to notify you of the request or, if such assurance is not forthcoming, if the Plan has made a reasonable effort to notify you about the request or to obtain an order protecting your health information.
- **For Law Enforcement Purposes.** As permitted or required by state law, the Plan may disclose health information to a law enforcement official for certain law enforcement purposes, including, in an emergency, to report a crime.
- **To Coroners, Medical Examiners and Funeral Directors.** The Plan may release health information to coroners or medical examiners for duties authorized by law or to funeral directors consistent with applicable law.
- **Organ and Tissue Donation.** If you are an organ donor, the Plan may release health information to organizations that handle organ procurement or transplantation.

- **In the Event of a Serious Threat to Health or Safety.** The Plan may disclose health information if necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public or another person.
- **For Specified Government Functions.** In certain circumstances, federal regulations may require the Plan to use or disclose health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others and correctional institutions and inmates.
- **For Workers' Compensation.** The Plan may release health information to the extent necessary to comply with laws related to workers' compensation or similar programs.
- **For Other Purposes.** Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only if you provide a written authorization. If you provide the Plan with written authorization to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made with your permission. The Plan may use or disclose your health information for other purposes not set forth in this Notice when the Plan is permitted to do so without your written authorization or consent.

Your Rights Regarding the Privacy of Personal Health Information

Any of the rights described below that you may exercise may also be exercised by your personal representative. The Plan will require an appointment of the representative that you have signed. You have the following rights:

- **The right to request restrictions or limitations on the health information the Plan uses or discloses about you for treatment, payment or health care operations.** However, the Plan is not required to agree to your request. To request restrictions, you must make your request in writing to the Plan's Privacy Officer. In your request, you must state:
    - What information you want to limit;
    - If you want to limit the Plan's use, disclosure or both; and
    - To whom the limits apply.
- **The right to request to receive confidential communication of your health information by an alternative means or at an alternative location if a disclosure of your health information could endanger you.** The request must be made in writing to the Plan's Privacy Officer and must specify the alternative location or other method of communication that you prefer (for example, using an alternate address). Your request must include a statement that the restriction is necessary to prevent a disclosure that could endanger you. The Plan does not refuse to accommodate such a request unless the request imposes an unreasonable administrative burden. If the request is granted, the documentation of your request will be placed in your record.

- **The right to access documents regarding your eligibility, payment of Claims, appeals or other similar documents for inspection and/or copying.** Your request for access to documents with your health information must be in writing to the Plan's Privacy Officer. When a request for access is accepted (in whole or in part), you will be notified of the decisions and you may then inspect the health information, copy it, or both, in the form or format requested at a time and place that is mutually convenient. If you would like, you may receive a summary of the requested health information instead of your entire record, for a reasonable fee. You may also receive a copy of your health information by mail if you prefer. (The Plan charges a reasonable, cost-based fee for copying, including labor and supplies, for instance, paper, computer disks and for postage if you request that the information be mailed. No fee is charged for retrieving or handling the health information or for processing your request for access.) When a request for access is denied in part, the Plan will grant access to the health information for which there is no grounds to deny access. The Plan will also inform you why your request for access was denied, how to appeal the denial (if the denial is reviewable) and how to file complaints with us and/or the U.S. Department of Health and Human Services. If you request a review and the denial is reviewable, the Plan will designate a licensed health care professional, not involved in the original denial decision, to serve as a reviewing official, and you will be notified in writing of the reviewing official's determination.
- **The right to request that your health information be amended if it is inaccurate or incomplete.** You may request that your health information be amended. That request must be in writing to the Plan's Privacy Officer and include a reason why your health information should be amended. If you do not include a reason, the Plan will not act on the request. When a request for amendment is accepted (in whole or in part), the Plan will inform you that your request for amendment has been accepted. The Plan will request from you permission to contact other individuals or health care entities that you identify that need to be informed of the amendment(s), and the Plan will inform them and other entities with whom the Plan does business who may rely on the disputed health information to your detriment. The Plan will identify the record(s) that are the subject of the amendment request and will append the amendment to the record. When a request for amendment is denied, you will be notified why the request was denied (e.g., the information requested was not created by the Plan, is accurate and complete, is not part of the record or may not legally be changed, such as information compiled in anticipation of a civil, criminal or administrative proceeding), how to file a statement of disagreement or a request that the Plan provide the request for amendment and the denial in any future release of the disputed health information and how to file a complaint with us or the U.S. Department of Health and Human Services. If you choose to write a statement of disagreement with the denial decision, the Plan may write a rebuttal statement and will provide a copy to you, and the Plan will include the request for amendment, denial letter, statement of disagreement and rebuttal (if any), with any future disclosures of the disputed health information. If you do not choose to write a statement of disagreement with the denial decision, the Plan is not required to include the request for amendment and denial decision letter with future disclosures of the disputed health information unless you request the Plan do so. When the Plan is notified that your health information has been amended, it will ensure that the amendment is appended to your records, and will inform entities with whom it does business that may use or rely on your health information of the amendment and require them to make the necessary corrections.

- **The right to obtain an accounting of disclosures of your health information.** You have the right to request the Plan to provide you with an accounting of its disclosure of your health information. The right to an accounting extends to disclosures, other than disclosures made:
  - For treatment, payment or health care operations, including those made to business associates;
  - To individuals about their own health information;
  - Incident to an otherwise permitted use or disclosure;
  - Pursuant to an authorization;
  - To persons involved in the patient's care or other notification purposes;
  - As part of a limited data set;
  - For national security or intelligence purposes;
  - To correctional institutions or law enforcement officials; and
  - Those made before April 14, 2003.

  To request an accounting of disclosures, you must submit your request in writing to the Plan's Privacy Officer. Your request must specify a period, which may not be longer than six years. You may request and receive an accounting of disclosures once during any 12-month period for no charge. If you request more than one accounting within the same 12-month period, a reasonable, cost-based fee may be charged. The Trust will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **The right to receive a paper copy of this Notice and any revisions to this Notice.** You may request a copy of this Notice in writing to the Plan's Privacy Officer at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Legal Effect of this Notice

The Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information we have about you as well as any information we receive in the future. If the Plan changes its policies and procedures, it will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services (HHS) if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to the Plan's Privacy Officer. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Plan Privacy Officer

For questions about this Notice, to exercise your privacy rights or to file a complaint, contact:

Steve Kokotovich, Plan Privacy Officer
UAW Retirees of the Dana Corporation Health & Welfare Trust
P.O. Box 1708
Troy, Michigan 48099-1708

Subrogation and Reimbursement

Any reference in this section to “you” also includes your covered dependent or you or your dependent’s assignee or representative.

If the Plan pays benefits for any Illness, Injury, expense or loss caused by a third party, the Plan is subrogated (acting as a substitute) to all rights you may have against any person, firm, corporation or other entity for any Claim related to the Illness, Injury, expense or loss, including any occupationally related Claim or cause of action covered by the any state or federal act, for the full amount of benefits paid by the Plan. All recoveries you receive from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse the Plan for benefits paid.

By accepting benefits provided by this Plan, you agree to reimburse the Plan for any benefits you may receive from a third party due to a judgment, settlement or otherwise, regardless of any offset for expenses, including legal fees, that you may owe, and before you pay any other individual, organization or entity out of that full or partial recovery. In other words, this Plan has first priority with respect to its rights under this subrogation rule. Any money you recover will be considered to be held in a constructive trust for the benefit of the Plan, regardless of who actually holds the money. You may not take any action that would prejudice the Plan’s rights, and you are required to take any action, provide any information and assistance and sign any papers required by the Plan for the Plan to be able to enforce its subrogation rights. The Plan (and/or any of the Plan’s designees) is not responsible for attorney’s fees or costs you may incur or pay unless the Plan agrees in writing to pay these fees or costs in full or in part. If for any reason any of the Plan’s subrogation rights are compromised or diminished in any way, the Plan may treat the benefit amounts you received as a debt you have to the Plan and the Plan may pursue recovery of that amount from you and/or reduce or eliminate any future benefits that may be payable on your behalf until this debt is paid.

Before the Plan’s payment of benefits for any Illness, Injury, expense or loss caused by a third party, you may be asked to sign a written assignment to the Plan of your rights, Claims, interests or causes of action up to the full amount of Plan benefits. In addition, you may be asked to authorize the Plan, at the Plan’s expense, to sue, compromise or settle, in your name or otherwise, all rights, Claims, interests or causes of action to the full extent of the benefits paid and to do nothing to prejudice the Plan’s subrogation rights. You may be asked to assure the Plan that you have not discharged or released any rights, Claims, interests or causes of action. However, the Plan’s failure to request or obtain any such document before payment of benefits does not in any way diminish the Plan’s subrogation and reimbursement rights.

You are expected to assist or cooperate with the Plan, including, if requested, by bringing legal proceedings against any appropriate persons, firms corporations or other entities. The Plan may withhold benefits if you do not assist or cooperate.

Plan Administrative Information

This section contains important information about the Plan that is described in this SPD. In this section you will find information about the Plan and your legal rights.

Trust Name

UAW Retirees of the Dana Corporation Health and Welfare Trust

Plan Name

UAW Retirees of the Dana Corporation Health and Welfare Trust. The benefits described in this SPD are for non-Medicare eligible participants.

Plan Sponsor and Plan Administrator

The Plan is sponsored and administered by the Committee. The Committee has seven members, four of whom are independent members and three of whom are appointed by the UAW. The Committee manages the Trust, designs and administers the benefit Plan and serves as the legal Plan Administrator and named Plan fiduciary under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. However, the Committee has delegated administrative responsibility to BeneSys, as the Fund Administrator.

Fund Administrator

The Committee hired BeneSys, Inc. as the Fund Administrator. BeneSys handles general Plan administration, including eligibility, recordkeeping, participant contributions and inquiries. To contact BeneSys:

BeneSys
P.O. Box 1708
Troy, Michigan 48099-1708
(248) 641-4903 or (866) 626-2070
Fax: (248) 813-9898

Plan Sponsor Employer Identification Number (EIN)

26-1851652

Plan Number

001

Plan Year

The Plan Year is January 1 and ending December 31.

Plan Type

This Plan is a welfare plan providing medical and prescription drug coverage for non-Medicare eligible participants.

Plan Funding

This Plan is self-funded, which means benefits are paid directly from the Trust out of its assets. No insurance company or other state licensed entity is responsible for the financing of the Plan. Benefits under the Plan are not guaranteed by a policy of insurance. Participant contributions for coverage are paid to the Trust.

Agents for Service of Legal Process

If legal disputes involving the Plan arise, any legal documents may be served on:

Andrew Nickelhoff, Esq. or Patricia J. Tarini, Esq.
Sachs Waldman, P.C.
1000 Farmer St.
Detroit, Michigan 48226.

Legal process also may be served on the Fund Administrator or on any Committee member at BeneSys.

Legal Actions

No action at law or equity may be brought for benefits until all appeal rights have been fully exhausted. Under Plan terms, any lawsuit brought against the Trust, Committee, any of the Committee members individually or any agent of any of these under or relating to the Plan, including the Fund Administrator and Claims Administrators, is barred unless the complaint is filed within three years after the right of action accrues, unless a shorter period is established by applicable statute, regulation or case law.

Plan Documents

This Summary Plan Description (SPD) is as accurate and up to date as possible. However, this SPD is only a summary of your benefits; full details of the Plan are included in the legal documents that govern the Plan.

In the case of any uncertainty regarding the meaning or intent of any section in the Plan, the interpretation of the Plan Administrator or the Plan Administrator’s designee will be final.

Plan Interpretation

Only the full Committee is authorized to interpret the Plan and decide eligibility for the benefits described in this booklet. The Committee's interpretation is final and binding on all persons dealing with the Trust or claiming a benefit from the Trust. If a decision of the Committee is challenged in court, that decision will be upheld, under current law, unless it is determined by the court to have been arbitrary and capricious. No agent, representative, officer or other person from Dana Corporation or the UAW has the authority to speak for the Committee or to act contrary to the written terms of the governing Plan Documents.

Plan Changes

The Committee may change the eligibility rules and/or benefit provisions of the Plan at any time. The benefits provided by the Trust are limited to the assets of the Trust that are available to pay benefits. No Employee, Retired Employee, Disabled Employee, Surviving Spouse or any other Covered Person has any vested rights to any benefit provided under the Plan, now or at any time in the future. The right to change or eliminate any and all aspects of benefits under the Plan is a right specifically reserved to the Committee.

Plan Discontinuation or Termination

The Trust and the Plan may be discontinued or terminated under certain circumstances, for example if there are insufficient assets in the Trust to continue payment of benefits or administration of the Plan. In this event, benefits for covered expenses incurred on or before the termination date will be paid as long as the Trust's assets are more than the its liabilities. Full benefits may not be paid if the Trust's liabilities are more than its assets, and benefit payments will be limited to the funds available. The Committee will not be liable for the adequacy or inadequacy of funds. If the Trust is terminated by action of the Committee, any assets remaining after payment of Trust liabilities will be used for purposes determined by the Committee according to the Trust Agreement.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. ERISA provides that you are entitled to the rights described in this section.

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator's office, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. A reasonable charge may be required for the copies.
- Receive a summary of the Plans' annual financial report (summary annual report), which is required by law to be provided to each participant.

Continue Group Health Plan Coverage

You may also have the right to:

- Continue health care coverage for yourself, Spouse or dependents (if eligible) if there is a loss of coverage due to a qualifying event. You or your dependents may have to pay for this coverage.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the Plan if you have creditable coverage from another plan. You will be provided a certificate of creditable coverage, free of charge, from the Plan when:
    - You lose Plan coverage;
    - You become entitled to elect COBRA continuation coverage; or
    - Your COBRA continuation coverage ends.

  You may request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called Plan fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including an employer, union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision (without charge) and to appeal any denial, all within certain time schedules. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's Claim and appeal procedures.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control.

If you have a Claim that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance with Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) or the national office at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
(866) 444-3272

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their website at www.dol.gov/ebsa.

Glossary

Allowable Expense

Any Usual and Customary fee, at least a portion of which is covered under at least one of the plans covering an individual for whom a Claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

Ambulatory Surgery Facility

A licensed facility that:

- Provides general surgery;
- Is directed by a staff of Physicians, at least one of whom must be on the premises when surgery is performed and during the recovery period;
- Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed and during the recovery period;
- Extends surgical staff privileges to Physicians who practice surgery;
- Has at least two operating rooms and one recovery room;
- Provides, or coordinates with a medical facility in the area for, diagnostic x-ray and laboratory services needed in connection with surgery;
- Provides in the operating and recovery rooms full-time skilled nursing services directed by a registered nurse; and
- Is equipped and has trained staff to handle medical emergencies, as follows:
    - Physician trained in cardiopulmonary resuscitation;
    - Defibrillator;
    - Tracheotomy set; and
    - Blood volume expander.

BlueCard Program

The national program comprised of Blue Cross and Blue Shield plans, which allows you to receive covered services from Providers who have a contract or agreement with another Blue Cross and/or Blue Shield plan located outside the geographical area served by Anthem. The local Blue Cross and/or Blue Shield plan that services the geographic area where the covered service is provided is referred to as the host Blue Cross and/or Blue Shield plan.

Calendar Year

The period from January 1 through December 31 of the same year.

Claim

A request for payment of Plan benefits.

Claims Administrator

The Claims Administrator is:

- Anthem Blue Cross Blue Shield Association of Wisconsin for medical Claims; and
- CVS Caremark for prescription drug Claims.

Committee

A committee that sponsors and administers the Plan.

Confinement

The period during which you are a registered inpatient for which a room and board charge is made. Confinement begins with admission and ends with discharge.

Continuous Period of Disability

Any two or more periods of disability caused by the same or related Illness or Injury that are not separated by more than three months.

Covered Person

You or your eligible dependent if you meet the Plan's eligibility requirements for coverage, satisfied any applicable waiting period and properly enrolled in the Plan.

Custodial Care

Care designed to help in the activities of daily living that does not require the continuous attention of trained medical or paramedical personnel. This care may involve preparation of special diets, supervision of medication that can be self-administered and assistance in getting in or out of bed, walking, bathing, dressing and eating.

CVS Caremark

CVS Caremark, the Plan's pharmacy benefit manager.

Dependent Child

Any biological child, step child or legally adopted child, including a child placed for adoption or legal guardianship, dependent on an Employee or Retired Employee for support on or before January 31, 2008.

Employee

You are considered an Employee if you were:

- An active employee of Dana Corporation on or before January 31, 2008;
- Covered by a collective bargaining agreement and/or plant closing agreement between Dana and UAW as of the date that you retired, became disabled under a Dana long-term disability plan or were an employee of a facility sold by Dana in one of the following locations:
  - Angola, IN;
  - Antwerp, OH;
  - Ashland, OH;
  - Auburn Hills, MI;
  - Auburn, IN;
  - Berwick, PA;
  - Bristol, VA;
  - Buena Vista, VA;
  - Cape Girardeau, MO;
  - Chelsea, MI;
  - Chicago, IL;
  - Columbia City, IN (brake plant);
  - Columbia City, IN (tool plant);
  - Ecorse, MI;
  - Elizabethtown, KY;
  - Fort Wayne, IN;
  - Hagerstown, IN;
  - Hamtramck, MI;
  - Lansing, MI;
  - Lima, OH;
  - New Castle, IN;
  - Plymouth, MN;
  - Pottstown, PA;
  - Richmond, IN;
  - Rushville, IN;
  - Syracuse, IN;
  - Toledo, OH; or
  - Warren, MI.

Experimental or Investigational

Any treatments, procedures, devices, drugs or medicines that:

- Cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished;
- Reliable evidence shows is the subject of ongoing phase I, II or III clinical trial(s) or under study to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis;
- Are educational or provided primarily for research;
- Relate to transplants of non-human organs, tissues or cells; or
- Reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

Fund Administrator

BeneSys, Inc.
P.O. Box 1708
Troy, Michigan 48099-1708
(248) 641-4903 or (866) 626-2070
Fax: (248) 813-9898

Home Health Aide Services

Services that may be provided by a qualified individual other than a registered nurse that are Medically Necessary for care and treatment.

Home Health Care

Services or supplies rendered to you or a covered family member in your home or your family member's home as an alternative to services and supplies provided as part of an inpatient Confinement in a Hospital or Skilled Nursing Facility.

Home Health Care Agency

An agency that:

- Is certified by a Physician as an appropriate Provider of Home Health Aide Services;
- Has a full-time administrator;
- Maintains daily clinical records of services provided;
- Includes on its staff at least one registered nurse to supervise nursing care; and
- Is coordinated by a state licensed Medicare certified Home Health Care Agency or certified rehabilitation agency.

Home Health Care Plan

Care and treatment for an Illness or Injury under a plan of Home Health Care established and approved in writing by an attending Physician. The Physician must also certify that the treatment for the Illness or Injury would otherwise require Confinement in a Hospital or a Skilled Nursing Facility. The Home Health Care Plan must be reviewed at least every two months.

Hospital

An institution that:

- Is duly licensed as a hospital (to the extent licensing is required by state or federal law);
- Is primarily engaged in providing medical care and treatment of Illness and Injury on an inpatient basis;
- Is an institution accredited by the Joint Commission on Accreditation of Hospitals or is a hospital that is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare;

- Provides organized facilities for laboratory, diagnostic services, medical treatment and surgery;
- Provides 24-hour nursing care by licensed registered nurses; and
- Has a staff of one or more licensed Physicians available at all times.

An institution that is primarily a rest home, nursing home, convalescent home, rehabilitation center, extended care facility or home for the aged is not considered a Hospital.

For behavioral health benefits, a facility approved under the laws of the state of its jurisdiction, for the treatment of Mental Health and Substance Abuse will be considered a Hospital for behavioral health treatment.

Illness

Pregnancy or a disease or disturbance in the function or structure of the body that causes physical signs and/or symptoms that, if left untreated, will result in a deterioration of the health state of the structure or systems of the body.

Injury

A condition caused by accidental means and from an external force that results in damage to the body.

Intensive Care Unit or Coronary Care Facility

A section, ward or wing within a Hospital that is operated solely for critically ill patients and provides special supplies, equipment and constant observation and care by registered nurses or other Hospital personnel.

Maximum Benefit

The total eligible charges the Plan pays per Covered Person while covered under the Plan.

Medically Necessary or Medical Necessity

A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, Physician or other health care Provider required to diagnose or treat an Illness or Injury and that is, as determined by the Claims Administrator and/or Plan Administrator:

- Consistent with the symptoms or diagnosis and treatment of the Illness or Injury;
- Appropriate under the standards of acceptable medical practice to treat that Illness or Injury;
- Not solely for the convenience of the patient, Physician, Hospital or other health care Provider; and
- The most appropriate service, treatment, procedure, equipment, drug, device or supply that can be safely provided and that accomplishes the desired end result in the most economical manner.

The fact that a Provider may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make that treatment, service or supply Medically Necessary.

Medicare

The program for health benefits under Title XVIII of the Social Security Act, as amended.

Mental Health

Mental, nervous or emotional disease or disorders of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders; regardless of the original cause of the disorder.

Primary Plan

A plan that determines and pays benefits first, without regard to any other plan.

Provider or Physician

Any person who is validly licensed to perform services and who is acting within the scope of that license.

For behavioral health, a Physician or Provider also includes any person approved or licensed by the state in which services are rendered for treatment of these conditions.

Secondary Plan

A plan that is not a Primary Plan according to coordination of benefits order of benefit determination rules, and whose benefits are determined after those of another plan and may be reduced because of the other plan's benefits.

Skilled Nursing Facility

A facility that:

- Is regularly engaged in providing skilled nursing care for Illness and Injury;
- Requires regular attendance by a Physician;
- Maintains a daily record for each patient;
- Provides 24-hour nursing care supervised by a registered nurse;
- Is not, except incidentally, a home for the aged, a hotel or the like;
- Is not, except incidentally, a place for the treatment of behavioral health; and
- Is licensed as a skilled nursing facility, if licensing is required.

Spouse

The person to whom you are legally married as of the date you become eligible to receive benefits as a Retired Employee or Disabled Employee on or before January 31, 2008.

Substance Abuse

The use of a psychoactive substance in a manner detrimental to society or the individual and that meets, or with continued use may meet, criteria for substance abuse or drug dependency.

Surviving Spouse

The surviving Spouse of a deceased Employee or Retired Employee that meets the Plan's eligibility requirements for coverage.

Trust

The UAW Retirees of the Dana Corporation Health & Welfare Trust.

Usual and Customary or U&C

The fee usually and customarily accepted as payment for the same services within a geographic area in which a Physician practices. For an in-network Provider, Usual and Customary is the negotiated, discount rate for the service or procedure.

Important Notice

The Committee has all powers necessary to administer and enforce Plan provisions. The Committee's decisions are final as to all questions arising in the administration, interpretation and application of the Plan. Any interpretation, determination, rule, regulation or similar action or decision issued by the Committee, or any person acting at the Committee's direction, will be conclusive and binding on all persons, except as otherwise provided, and any such determination, rule, regulation or similar decision may not be set aside unless it is determined by a court of competent jurisdiction that the Committee acted in an arbitrary and capricious manner. Plan benefits are paid only if the Committee or its designee decides, in its discretion, that the applicant is entitled to them.