

UAW St. Joseph Retirees Health and Welfare Trust

SUMMARY PLAN DESCRIPTION

January 1, 2021

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Introduction

The UAW St. Joseph Retirees Health and Welfare Trust provides medical (including prescription drug), dental and vision benefits for Medicare-Eligible participants. This Summary Plan Description (SPD) describes the benefits available as of January 1, 2021.

When you become eligible for this Plan and for Medicare, you must:

- Sign up for Medicare Parts A and B as soon as you become eligible.
- Notify BeneSys to enroll in this Plan. You must send a copy of your Medicare enrollment verification or Medicare card to BeneSys as soon as it is received. If you are transitioning from coverage for non-Medicare eligible participants; this is essential to continue coverage without a break.
- 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 Plan.

A Voluntary Employee Beneficiary Association (VEBA) trust fund (Fund) was established in December 2009 as part of the settlement of a class action lawsuit brought by the UAW and individual retirees against Robert Bosch LLC (Bosch). The Fund is sponsored and administered by a Committee of seven members, which includes individuals with experience in health care and finance as well as UAW representatives. The Committee manages the Fund, designs and administers the benefit Plan and serves as the legal Plan Administrator and named fiduciary. The Fund is independent from both Bosch and the UAW.

The Committee reserves the right, at any time, to modify, amend or terminate any existing or future benefit or condition of eligibility or self-payment or any other term or condition of the Plan.

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

Please take time to read this SPD and familiarize yourself with your health care benefits. By reading each section carefully, you will understand your benefits and know how to use them wisely. You'll also learn about any out-of-pocket expenses that are your responsibility. When you come across a word you don't understand, look in the Glossary at the back of the SPD. It contains the definitions of many health care terms that may be unfamiliar to you.

This SPD is only a summary of your benefits. Full details of the Plan's benefits are set forth in the official Plan documents – which are the certificates, policies and schedules of the insurance carriers and benefit providers, the policies of the Committee and other documents that govern the Plan. In case of conflict between this SPD and the official Plan documents, those official Plan documents and not this SPD will govern, unless this SPD specifically states to the contrary. 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 Administrative Manager to whom such authority has been delegated. The Committee has the right to interpret the Plan, and to change or eliminate benefits or amend or

terminate the Plan at any time. The Committee's interpretation of the Plan is final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Committee, or its delegate, 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.

As a reminder, the Participant Website is available to all eligible participants. The website will provide key contact information, forms and documents that will help you get the most out of your benefits.

The address is www.ourbenefitoffice.com/uawstjosephretirees

Please take some time to familiarize yourself with all it has to offer.

If any material changes are made to the Plan after the date of this SPD, you will receive a Summary of Material Modifications, which includes a statement of significant changes in the Plan after the date of this SPD if any material changes are made to the Plan. Like this SPD, it is intended as a general statement of the changes and is not a substitute for other formal documents governing the terms of the Fund's coverage and eligibility rules.

If you have specific questions or need any assistance, contact the Administrative Manager. Contact information for the Plan Administrator can be found below and in the Plan Administrative Information Section. When calling the Trust or any provider's customer service, please remember to document the date, time, name and department of the representative you speak with. This could help locate your call should there be any discrepancies or questions in the future.

Your Responsibilities

The Plan is designed to help you meet your medical, dental and vision 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 Fund ID cards (medical/prescription drug, dental and vision) with you and show them whenever you receive medical, dental or vision 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.
- **Enroll in Medicare as Soon as You are Eligible** due to age, disability or end stage renal disease (ESRD). If you are not yet 65 or otherwise disabled but have ESRD, you will become entitled to/eligible for Medicare on the first day of the third month following the month when you first started dialysis. If you receive a transplant, your entitlement/eligibility for Medicare will start two months before the transplant. If you perform self-dialysis, your entitlement/eligibility for Medicare starts the month that you begin your dialysis. Be sure to enroll in Medicare Parts A and B or you will not be covered under this Plan.
- **Keep the Administrative Manager 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 change in other medical, prescription drug, dental or vision insurance coverage of a family member covered by the Plan.

- **Identify Yourself.** If you need to contact BeneSys, be sure to include your name and your member ID number or 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, just your member ID number or the last four digits of your Social Security number. If you call, please be sure to have your member ID number or complete Social Security number handy.
- **Stay Current with your Medicare Premiums.** While contributions are not currently required to be made for this coverage, you must pay your monthly contribution for Medicare Part B coverage (most people do not pay a contribution for Medicare Part A). These payments are paid to Medicare. If you do not pay your Medicare premiums, it will result in a loss of coverage under this Plan.
- **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 Fund.** 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.

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:** (877) 941-4909 or (248) 641-4909
- **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 plans, policies and schedules of the carriers, the policies of the Committee and other documents that govern the Plan. The UAW St. Joseph Retirees Health and 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 Plan Administrator to whom such authority has been delegated. In case of conflict, the plans, policies and schedules of the carriers, the policies of the Committee and other documents that govern the Plan, not this summary booklet, will govern, unless this summary specifically states to the contrary. 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 St. Joseph Retirees Health and Welfare Trust. You will not be able to enroll in this Plan until you are eligible for this Plan under Plan rules (as described in this section) and Medicare rules, which means that you must be eligible for Medicare Parts A and B.

Enrollment in Medicare

This Plan only covers individuals who are eligible for coverage under the rules of the Plan **and** who are eligible for Medicare.

As soon as you become eligible for Medicare, you must:

- **Sign up for Medicare Parts A and B.**
- **Notify BeneSys to enroll in this Plan.** You must send a copy of your Medicare enrollment verification or Medicare card to BeneSys as soon as it is received. If you are transitioning from coverage for non-Medicare eligible participants; this is essential to continue coverage without a break.
- **Not sign up for an individual Medicare Part D prescription drug plan.** If you sign up for an individual Medicare Part D plan, you will not receive medical or prescription drug coverage from this Plan.

Retired Employee Eligibility

You are eligible for coverage under this Plan as a Retired Employee if you:

- Were an hourly rated employee of Bosch's St. Joseph, Michigan Plant (Chassis Systems Full Brakes, North America), who was covered under collective bargaining between Bosch and the UAW covering the St. Joseph, Michigan Plant;
- Retired before January 1, 2010 under the Bosch Braking Systems Pension Plan for Hourly Employees with eligibility for retirement medical benefits; and
- Are eligible for Medicare due to age or disability.

Dependent Eligibility

Only a dependent that is eligible for Medicare can be covered under this Plan.

You are eligible for coverage as a dependent of a Retired Employee if you are the:

- Spouse of an eligible Retired Employee, provided you were continuously married to the Retired Employee since the time he or she retired and you are eligible for Medicare; and
- Dependent child of an eligible Retired Employee provided you were eligible as a dependent at the time the Retired Employee retired and you are eligible for Medicare.

For coverage eligibility, if you are a Retired Employee, a dependent child includes your:

- Child by birth, legal adoption or legal guardianship who is legally residing with and dependent on you;
- Spouse's child who is in the custody of and dependent on your Spouse provided your Spouse is legally responsible for the child's health care; and
- Child who lives with you, is related to you by blood or marriage, for whom you provide principal support (as defined by the Internal Revenue Code of the United States), who you reported as a dependent on your most recent income tax return and who qualifies in the current year for dependency tax status.

As long as a child is otherwise eligible, coverage will continue until the last day of the month in which the child reaches age 19. However, coverage may be extended until the last day of the month in which the child reaches age 25 if the child is a full-time student at an accredited secondary school, college or university.

The Retired Employee or Surviving Spouse of the Retired Employee is responsible for notifying the Trust of any change of status which results in a covered dependent losing eligibility under the Plan rules. This includes but is not limited to: a death, legal separation, divorce, termination of adoption, or a termination of a legal guardianship or custody order. If any such change of status occurs, you must notify BeneSys immediately.

Please Note: The Retired Employee or Surviving Spouse of the Retired Employee will be responsible for reimbursing the Trust for the cost of any benefits which are provided to a dependent who has become ineligible due to a change of status if the retiree or surviving spouse failed to provide notice to the Trust of such change of status. In addition, failure to inform the Trust of such a change of status may constitute fraud entitling the Trust to suspend retiree and dependent benefits in addition to seeking reimbursement.

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 (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 child under a QMCSO will

be provided for as long as the child satisfies the definition of dependent for the applicable benefits and the QMCSO remains in effect.

Surviving Spouse and Child Eligibility

You are eligible for coverage as a Surviving Spouse if you are eligible for Medicare and:

- You were the spouse of an hourly rated employee of Bosch's St. Joseph, Michigan Plant (Chassis Systems Full Brakes, North America) who died before January 1, 2010 and the deceased employee was eligible for Surviving Spouse coverage at the time of death; or
- You were the spouse of a retiree who was covered by the Trust (or had a future right to coverage) and were eligible for coverage as a spouse of the retiree (or had a future right to be eligible for coverage) .

You are eligible for coverage as the child of a Surviving Spouse if you:

- Were the dependent of an hourly rated employee of Bosch's St. Joseph, Michigan Plant (Chassis Systems Full Brakes, North America) who died before January 1, 2010, the deceased employee was eligible for Surviving Spouse coverage at the time of death and you were eligible for coverage under this Plan as a dependent child of the deceased employee at the time of death; and
- Are eligible for Medicare.

Enrolling for Coverage and When Coverage Begins

As previously noted, you must meet the Plan's eligibility requirements to be eligible for Plan coverage and you must be eligible for Medicare Parts A and B. You should enroll in Medicare as soon as you become Medicare-eligible.

At the time you first become eligible for the Plan as a Retired Employee, Retired Employee's Spouse and/or dependent child, Surviving Spouse or Surviving Spouse's dependent child, you must complete and file an enrollment application with BeneSys. You must file your enrollment application with BeneSys **no later than 30 days** after your eligibility for Medicare Parts A and B (or as otherwise noted in [Delayed Enrollment](#) below). You must provide BeneSys with a copy of your Medicare enrollment verification or Medicare card as well as other documentation required by BeneSys (such as birth certificates, proof of guardianship, adoption papers, marriage certificates, etc.) within 30 days of becoming eligible. Coverage will not begin before the enrollment application and documentation are received, so it is to your benefit to provide the notice and the documentation to BeneSys as quickly as possible.

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

Also Note: The Medicare Modernization Act imposes a lifetime late enrollment penalty (LEP) on individuals who do not maintain "creditable coverage" for a period of 63 days or longer following their initial enrollment period for the Medicare prescription drug benefit. Accordingly, this information is essential to an individual's decision whether to enroll in a Medicare Part D prescription drug plan. Therefore, if you fail to timely enroll in the Plan within the required 30 days of becoming eligible and you wish to purchase other prescription drug coverage in order

to avoid a lifetime LEP that you will have to pay, you must sign up for other Medicare Part D coverage before **63 days** have elapsed between when your other prescription drug coverage ends and when you are enrolled in another Medicare Part D prescription drug plan. See: <http://www.cms.hhs.gov/CreditableCoverage/> for additional information.

Delayed Enrollment

You may delay enrollment in the Plan if you meet all other requirements for enrollment and participation in the Plan 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 60 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 60 days after your qualified coverage ends.

If you do not request delayed enrollment as previously described 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.

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. Delayed enrollment will not prevent the imposition of a lifetime late enrollment penalty if you do not maintain other "creditable coverage" for a period of 63 days or longer following your initial enrollment period for the Medicare prescription drug benefit.

Contact BeneSys with any questions about delaying your enrollment.

Continuing Coverage

You continue to be eligible for coverage as long as you meet the eligibility requirements.

Medicare Premiums: While contributions are not currently required to be made for this coverage, you must pay your monthly contribution for Medicare Part B coverage (most people do not pay a contribution for Medicare Part A). These payments are paid to Medicare. If you do not pay your Medicare premiums, it will result in a loss of coverage under this Plan.

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 can be extended beyond the date it would normally end, as explained in this section and in the [COBRA Continuation Coverage](#) section on page 10.

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;
- Date you are no longer covered by 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.

Spouse

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

- Date of your death;
- Date on which the Retired Employee with whom the Spouse is covered is no longer covered by the Plan;
- Date of your divorce or legal separation from a Retired Employee;
- Date you are no longer covered by 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 Employee or Surviving Spouse with whom the dependent child is covered is no longer covered by the Plan;
- Date the child is no longer covered by Medicare; or
- Date the Plan terminates.

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 a Medicare-eligible:

- Covered Spouse of a Retired Employee; and
- Dependent child of a Retired 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.

Qualifying Events

COBRA continuation coverage may be purchased as follows:

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

Notify the Administrative Manager of Qualifying Events

You or the qualified beneficiary must notify BeneSys within 60 days of when a qualifying event occurs, including the death of a Retired Employee or Surviving Spouse, or divorce or legal separation. If you or the qualified beneficiary do not notify the Administrative Manager within 60 days of the qualifying event, the qualified beneficiary will lose the right to elect COBRA continuation coverage. 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 minor 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 Administrative Manager 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. This will result in a lapse of continuous coverage under the Plan.

COBRA continuation coverage must be elected no later than 60 days after the date of the COBRA Election Notice. 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 Administrative Manager 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 Administrative Manager 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 Administrative Manager at:

BeneSys
P.O. Box 1708
Troy, Michigan 48099-1708
(877) 941-4909 or (248) 641-4909
Fax: (248) 813-9898

Medical and Prescription Drug Benefits

The Trust provides Medical and Prescription Drug Benefits for Medicare-eligible participants through Blue Cross Blue Shield of Michigan's Medicare Plus Blue Group PFFS, which is a Medicare Advantage Private-Fee-for-Service (PFFS) plan. Full details of the program's benefits are set forth in the official Plan documents – which are the certificates, policies and schedules of the insurance carriers and benefit providers, the policies of the Committee and other documents that govern the Plan. In case of conflict between this SPD and the official Plan documents, those official Plan documents and not this SPD will govern.

For more information about this Plan, contact BeneSys or Blue Cross Blue Shield of Michigan (BCBSM):

- Online at www.bcbsm.com; or
- By phone at (866) 684-8216; Member Services representatives are available Monday through Friday, from 8:30 a.m. to 5 p.m., ET (TTY/TDD users call (800)-579-0235).

For more information about Medicare, you can:

- Call (800) MEDICARE (633-4227), TTY users should call (877) 486-2048; available 24 hours a day, 7 days a week; or
- Go online to www.medicare.gov.

How the Plan Works

- **Medicare Premiums:** To be covered under the Plan, you must pay premiums to Medicare (for your Medicare Part B medical coverage).
- **Providers:** You can receive care from any provider who accepts Medicare and this Plan's terms. The Plan uses a network of approved medical care providers, which includes physicians, hospitals and other medical facilities. The Plan's network is administered by BCBSM. Providers in the network, which can change at any time, have agreed to accept this Plan's terms.

Deductible: The amount of covered expenses you must pay each year before the Plan begins to pay most benefits. Some services are not subject to the deductible – please see the Summary of Medical Benefits.

- **Copayment:** A copayment is a flat dollar amount that you pay for certain covered services, such as physician office visits and prescription drugs.
- **Plan Payment:** Once you reach your deductible, the Plan covers 100% of the cost of covered in-network services; except for prescription drug expenses, as noted above. Most out of network services are covered at 95% after the deductible. The remaining 5% is your share of the cost and is often referred to as Coinsurance.
- **Maximum Benefits:** Certain covered expenses may be limited to a specific maximum, as described in the [Summary of Medical Benefits](#), beginning on page 15.
- **Out of Pocket Maximum:** the most that you will be expected to pay in any year.

Finding an In-Network Health Care Provider

To find an in-network health care provider, contact BCBSM by:

- Going online to www.bcbsm.com/medicare; or
- Calling (800) 810-BLUE (2583), TTY/TDD users call (800) 579-0235.

Summary of Medical Benefits

The Plan bases payment on the Medicare-approved amount, based on Medicare guidelines. The following services and supplies are covered under this Plan.

Plan Feature	Coverage (Services with a ¹ may require prior authorization)	
	In Network	Out of Network
Annual Deductible	\$300 per person (applies to in- and out-of-network claims on a combined basis)	
Out of Pocket Maximum (deductible, copayment and coinsurance all apply)	\$1,500	\$3,000 to a combined in- and out-of-network limit of \$4,500
Physician Office Visit (includes diagnostic hearing, outpatient substance abuse, podiatry and vision)	You pay a \$10 copayment and then Plan pays 100% of covered expenses.	You pay a \$20 copayment and then Plan pays 100% of covered expenses.
Inpatient Hospital ¹	Plan pays 100%, no days limit, including mental health and substance abuse stays.	
Skilled Nursing Facility ¹	After deductible, Plan pays 100%, up to 100 days per Benefit Period, when provided in a Medicare-certified skilled nursing facility. The day-limit renews when you have been out of a hospital or skilled nursing facility for 60 days in a row.	
Home Health Care ¹	Plan pays 100%; covered services include visiting nurse services and medically necessary intermittent skilled nursing care, home health aide services, home infusion and rehabilitation services.	

Plan Feature	Coverage (Services with a ¹ may require prior authorization)	
	In Network	Out of Network
Hospice	Plan pays 100% when provided at a Medicare-certified hospice. Claims must be submitted under the original Medicare first before this Plan begins to pay. Member may be responsible for part of the cost for respite care and hospice-related outpatient drugs.	
Physical Exams	Plan pays 100% for one “Welcome (Physical)” exam within your first 12 months of Medicare Part B coverage.	
Preventative Services	Plan pays 100% of all preventative services as determined by Medicare.	
Chiropractic Services ¹	You pay a \$10 copayment per visit, and then Plan pays 100% for covered manual manipulation of the spine.	You pay a \$20 copayment per visit, and then Plan pays 100% for covered manual manipulation of the spine.
Podiatry Services	You pay a \$10 copayment per office visit, and then Plan pays 100% for medically necessary services, such as surgery and X-rays.	You pay a \$10 copayment per office visit, and then Plan pays 95% for medically necessary services, such as surgery and X-rays.
Outpatient Services (including Mental Health and Substance Abuse Care) and Surgery	After deductible, Plan pays 100% when provided by a Medicare-certified provider.	After deductible, Plan pays 95% when provided by a Medicare-certified provider.
Ambulance Services ¹	After deductible, Plan pays 100% when provided by a Medicare-certified provider.	After deductible, Plan pays 95% when provided by a Medicare-certified provider.
Emergency Room	<p>You pay \$65 per visit (waived if you are admitted within 3 days).</p> <p>You may go to any emergency room if you reasonably believe you need emergency care.</p>	

Plan Feature	Coverage (Services with a ¹ may require prior authorization)	
	In Network	Out of Network
Urgent Care	You pay a \$10 copayment and then Plan pays 100% of covered expenses.	
Podiatry Medically necessary foot care services other than office visits ¹	Plan pays 100% up to the approved amount.	After deductible, Plan pays 95% of approved amount.
Outpatient Rehabilitation Services ¹	After deductible, Plan pays 100% for occupational, physical, speech and language therapy; coverage is limited to Medicare's outpatient rehabilitation caps.	After deductible, Plan pays 95% for occupational, physical, speech and language therapy; coverage is limited to Medicare's outpatient rehabilitation caps.
Durable Medical Equipment ¹	Plan pays 100% of covered equipment up to the approved amount.	After deductible, Plan pays 95% of approved amount.
Prosthetic and Orthotic Devices ¹	Plan pays 100% up to approved amount; includes coverage for braces, artificial limbs, eyes, etc.	After deductible, Plan pays 95% of approved amount.
Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies <i>(Medical supplies obtained at a pharmacy such as test strips, lancets, etc. are covered under the Plan's Prescription Drug Benefits)</i>	<p>Plan pays 100%; includes coverage for glucose monitors, test strips, lancets, screening tests and self-management training.</p> <p>In addition, Plan pays 100% of some diabetes supplies obtained from durable medical equipment suppliers.</p> <p>Diabetic shoes are covered up to 100% of approved amount after deductible.</p>	
Diagnostic Tests, X-Rays and Lab Services ¹ (costs for these services may vary based on place of service)	Plan pays 100%; includes coverage for Medicare-approved clinical lab services.	After deductible, Plan pays 95%.
Kidney Disease and conditions Dialysis Services ¹ Professional Services	After deductible, Plan pays 100% of approved amount.	After deductible, Plan pays 95%.

Plan Feature	Coverage (Services with a ¹ may require prior authorization)	
	In Network	Out of Network
Bone Mass Measurement	If you are at risk, Plan pays 100% once each year.	
Colorectal Screening Exams	Plan pays 100%; limited to once each year for screening barium enema, colonoscopy and flexible sigmoidoscopy. Plan pays 100% for fecal occult blood tests and multi-target stool DNA test.	
Immunizations	Plan pays 100% for: <ul style="list-style-type: none"> • One flu vaccine per season. • One pneumococcal vaccine per lifetime (or more frequently if certain criteria are met). • Hepatitis B vaccine if you are at risk. • Other Medicare-approved immunizations. 	
Mammograms	Plan pays 100%; limited to once each year.	
Pap Screens and Pelvic Exams	Plan pays 100%.	
Prostate Cancer Screening Exams	Plan pays 100% for: <ul style="list-style-type: none"> • Approved lab services. • One prostate screening per year. • One digital rectal exam per year. 	
Cardiovascular Screening and behavioral therapy	Plan pays 100%.	
Alcohol misuse screening and counselling	Plan pays 100%.	
Abdominal aortic aneurysm screening	Plan pays 100%.	
Depression screenings	Plan pays 100%.	
Diabetes screenings	Plan pays 100%.	
Screenings	Plan pays 100% for screenings for glaucoma, Hepatitis C, HIV, pneumococcal infection and obesity.	

Plan Feature	Coverage (Services with a ¹ may require prior authorization)	
	In Network	Out of Network
Tobacco Use Cessation	If you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco, Plan pays 100% for two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.	
End Stage Renal Disease	Plan pays 100% of Medicare-approved dialysis and facility charges when ESRD services are provided on an outpatient basis.	
Hearing Services	Plan pays 100% for diagnostic hearing office visits, diagnostic testing and routine exams.	
Hearing Aids	Plan pays 100% of basic binaural hearing aids up to \$2,500 once every 36 months. You are responsible for the cost of any hearing aid that exceeds the coverage limit.	
Vision Services	Plan pays 100% for an annual glaucoma screening if you are at risk, corrective lenses following cataract surgery, office visits for vision services and diagnosis and treatment of eye conditions and diseases.	
Silver Sneakers	Covered up to 100%. The Silver Sneakers Fitness Program is a specialized program for seniors that provides access to equipment, classes, and fun social activities at thousands of locations nationwide.	

Prescription Drug Coverage

Summary of Prescription Drug Benefits

The Plan's Prescription Drug Benefits provide coverage for Medicare Part B and Part D medications. The following table shows how much you pay:

Note: See the [Formulary—Preferred Medications](#) section on page 22 for information on preferred medications.

Prescription Drug Benefits	Retail or Mail Order Pharmacy
Preferred Generic (Tier 1) 1-Month (up to 31-day) Supply 3-Month (up to 90-day) Supply	You pay: \$0 copay \$0 copay
Generic (Tier 2) 1-Month (up to 31-day) Supply 3-Month (up to 90-day) Supply	You pay: \$0 copay \$0 copay
Preferred Brand (Tier 3) 1-Month (up to 31-day) Supply 3-Month (up to 90-day) Supply	You pay: \$20 copay \$40 copay
Non-Preferred Brand (Tier 4) 1-Month (up to 31-day) Supply 3-Month (up to 90-day) Supply	You pay: \$20 copay \$40 copay
Specialty Medication and Non-Self-Administered Injectable (Tier 5)	You pay: \$40 copay for a 1-month (up to 31-day) supply Note: Tier 5 medications are not available through the mail order pharmacy.
Catastrophic Coverage Limit (The limit and copays are set by CMS each year)	Generally, once you have paid \$5,100 out of your pocket in a Calendar Year, for the remainder of the Calendar Year you pay the greater of 5% of the cost of the medication or: <ul style="list-style-type: none"> • \$3.40 copay for a generic medication; or • \$8.50 copay for a brand name medication.

If the actual cost of a prescription is less than your cost, as noted in the chart, you pay the actual cost. However, you may have to pay more than the amounts listed above if you choose to use a higher cost medication when a lower cost medication is available. This may also occur if a new, lower cost generic version of a brand name medication is added to the plan's formulary. There are certain medications that will be provided at no cost the first time you have a prescription filled; these medications will be listed as "free first fill" on the Medicare Plus Blue Group PFFS web site, formulary and printed materials.

Note:

- Not all retail pharmacies will fill a 90-day supply of your medication.
- Some medications may have quantity limits.
- You may be required to first try one medication to treat your condition before the Plan will cover another medication for that condition.
- You may be required to get prior authorization from Medicare Plus Blue Group PFFS for certain drugs.

Medicare Part B Prescription Drugs

The Medicare Plus Blue Group PFFS covers Medicare Part B prescription drugs. Some outpatient prescription drugs that may be covered under Medicare Part B include, but are not limited to:

- Antigens if they are prepared by a physician and administered by a properly instructed person under physician supervision.
- Osteoporosis injectable drugs for certain women.
- Erythropoietin, by injection, if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Self-administered clotting factors if you have hemophilia.
- Injectable and infused drugs administered incident to a physician's service.
- Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare or paid by private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some oral cancer drugs if the same drug is available in injectable form.
- Oral anti-nausea drugs if you are part of an anti-cancer chemotherapeutic regimen.
- Oral end-stage renal disease drugs, if injectable and the drug is covered under Part B ESRD benefit.
- Inhalation and infusion drugs used with durable medical equipment.
- Self-administered drugs in hospital outpatient settings.
- Intravenous Immune Globulin (IVIG) provided in the home.

Pharmacy Network

The Plan includes a nationwide retail pharmacy network and mail order pharmacy administered by the Medicare Plus Blue Group PFFS. You may go to any pharmacy to have your prescription filled; however, you may pay more if you do not use a pharmacy that participates in the network (preferred pharmacy).

You must go to certain pharmacies for a limited number of medications, due to special handling, provider coordination or patient education requirements that cannot be met by most pharmacies. These medications are listed on Medicare Plus Blue Group's Web site, formulary and printed materials.

Pharmacies in the network can change at any time. To locate a network pharmacy, call Member Services at (866) 684-8216 (TTY (800) 579-0235) or visit www.bcbsm.com/ma/.

Formulary—Preferred Medications

The Plan uses a formulary. A formulary is a list of safe, effective and FDA-approved prescription drugs. Medications on the Plan's formulary are considered "preferred medications."

A copy of the formulary is available at www.bcbsm.com/medicare. Medications on the list may change periodically; new medications added or removed. If a formulary change affects your prescription, you will be notified.

Medication Therapy Management (MTM) Program

Medicare Plus Blue Group PFFS includes a free Medication Therapy Management (MTM) Program designed for specific health and pharmacy needs. You may be invited to participate in the program. While you are not required to participate, you may want to take advantage of this program if you are invited.

Note: Some over-the-counter medications are less expensive than prescription drugs and work just as well. For this reason, the Plan pays for certain over-the-counter medications as part of a utilization management program. Contact BCBSM for details.

Exclusions

Only expenses that are covered by Medicare may be covered under this Plan. Any service or supply excluded by Medicare is not covered under this Plan, unless specifically listed otherwise.

In addition, the Plan's Medical Benefits do not cover:

- Dental services (these expenses may be covered under the Plan's Dental Benefits).
- Certain eye exams, glasses and contact lenses (these expenses may be covered under the Plan's Vision Benefits).
- Private duty nursing.

Dental Benefits

Dental Benefits provide coverage for eligible dental expenses for you and your covered dependents. Dental Benefits are administered by Cigna.

For more information about your Dental Benefits, contact the Administrative Manager or Cigna at (800) CIGNA24 (244-6224)

Dental Network Providers

You may receive services from any dentist you choose, however, the Plan includes a network of dentists through Cigna available for your use, called the Cigna Radius Network. If you use a dentist from the network (network provider), he or she will typically charge less than a non-network provider. Therefore, using network providers will lower your out-of-pocket costs.

When you use a non-network provider, the Plan bases payment on the 90th percentile of what most providers charge for the same or similar service.

A listing of network dentists in the Cigna Radius Network is available by calling Cigna at (800) CIGNA24 (244-6224). When making your appointment, be sure to check that your provider participates in the network as providers change often.

How Your Dental Benefits Work

Whether you receive care from a network or non-network provider, you and the Plan share in the cost of your care, up to a Calendar Year (annual) maximum per person. The percentage that the Plan pays vary based on the type of service provided:

- Class I: Preventive and diagnostic;
- Class II: Basic restorative;
- Class III: Major restorative; and
- Class IV: Orthodontia, which is only available for dependent children up to age 19.

All Class I, II and III eligible expenses apply toward the annual maximum. Class IV eligible expenses are subject to a separate lifetime maximum per person. Network and non-network provider expenses are combined in considering if a maximum is met.

Summary of Dental Benefits

The following chart is intended as an overview; additional information is included in this section and is available by contacting Cigna directly at (800) CIGNA24 (244-6224).

Cigna Dental PPO	Network	Non-Network
Annual Deductible	None.	None.
Class II and III Annual Maximum	Plan pays up to \$2,000; network and non-network combined (does not apply to Class I).	Plan pays up to \$2,000; network and non-network combined (does not apply to Class I).
Class I: Preventive and Diagnostic	Plan pays 100%.	Plan pays 100%.
Class II: Basic Restorative	Plan pays 80%.	Plan pays 80%.
Class III: Major Restorative	Plan pays 50%.	Plan pays 50%.
Class IV: Orthodontia <i>Only available for covered individuals up to age 19.</i> Lifetime Maximum	Plan pays 50%, up to lifetime maximum \$2,000; network and non-network combined.	Plan pays 50%, up to lifetime maximum \$2,000; network and non-network combined.

Dental Covered Expenses

Class I: Preventive and Diagnostic

Class I preventive and diagnostic services include:

- Oral exams, limited to two per Calendar Year;
- Cleanings (prophylaxis), limited to two per Calendar Year;
- Fluoride applications, limited to one per Calendar Year;
- Space maintainers, limited to non-orthodontic treatment for individuals up to age 19; and
- Emergency care to relieve pain.

Class II: Basic Restorative

Class II basic restorative services include:

- Routine X-rays, limited to one bitewing X-ray every six months;
- Non-routine X-rays, limited to:
 - One full-mouth X-ray every three Calendar Years; and
 - One panorex X-ray every three Calendar Years;
- Fillings;
- Oral surgery for simple extractions (other oral surgery may be covered as a Class III service);
- Anesthetics;
- Minor periodontics (major periodontics are covered as Class III services), including:
 - Non-surgical, various limitations may apply depending on the service provided; and
 - Perio surgery, various limitations may apply depending on the service provided;
- Root canal therapy/endodontics;
- Relines and rebases when provided more than six months after installation;
- Repairs of bridges, dentures and partials (repairs are subject to review if more than once and replacements are limited to once every five years);
- Repairs of crowns, inlays and onlays; and
- Adjustments to installations when provided more than six months after installation.

Class III: Major Restorative

Class III major restorative services include:

- Oral surgery (simple extractions are covered as a Class II service);
- Major periodontics (minor periodontics are covered as a Class II service), models may be covered when part of extensive perio treatment;
- Apicoectomy/periradicular surgery;
- Denture adjustments;
- Dentures; and
- Bridges.

Class IV: Orthodontia

Class IV orthodontia services are available to covered individual up to age 19 and are limited to the lifetime maximum listed in the [Summary of Dental Benefits](#) on page 24. Each month of treatment is a separate dental service. Orthodontia services may include:

- Orthodontic work up including X-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances
- Continued active treatment after the first month
- Fixed or removable appliances (only one appliance per person for tooth guidance or to control harmful habits)
- Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

Note: Dental Benefits do not include any pre-existing condition exclusions, such as no coverage for teeth missing before coverage began.

Pretreatment Review

A pretreatment review allows you to find out, before you incur any expenses, the:

- Estimated cost for treatment;
- Estimated benefit payment; and
- Possible alternative treatments that may be more cost-effective.

A pretreatment review does not guarantee benefits from the Plan. However, it can help you understand more about how the Plan works for your specific need so you can make an informed decision about treatment.

You should request a pretreatment review when you do not know if the procedure is covered under the Plan or if the work is expected to cost \$200 or more.

Contact Cigna at (800) CIGNA24 (244-6224) to request a pretreatment review.

Alternate Benefit

When more than one covered dental service could provide suitable treatment based on common dental standards, Cigna will determine the covered dental service on which payment will be based and the expenses that will be included as covered expenses.

Dental Exclusions

Dental Benefits will not be paid for any of the following:

- Services performed primarily for cosmetic reasons.
- Replacement of a lost or stolen dental appliance.
- Replacement of a bridge or denture within five years of the date of its original installation.
- Replacement of a bridge or denture that can be made useable according to accepted dental standards.
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth or restore occlusion.
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars.
- Bite registrations.
- Precision or semi-precision attachments.
- Splinting.
- Surgical implants of any type.
- Instruction for plaque control, oral hygiene or diet.
- Dental services that do not meet common dental standards.
- Services that are considered medical services (these services may be covered under the Plan's Medical Benefits).
- Services and supplies received from a hospital (these services may be covered under the Plan's Medical Benefits).
- Charges you are not legally required to pay.
- Charges made by a hospital that performs services for the U.S. Government if the charges are directly related to a condition connected to military service.
- Experimental or investigational procedures or treatments.
- Any injury resulting from, or in the course of, any employment for wage or profit.
- Any sickness covered under any workers' compensation or similar law.
- Charges in excess of the reasonable and customary allowances.
- To the extent payment is unlawful where you reside when the expense is incurred.
- Procedures performed by a dentist who is a member of your family (limited to your Spouse, siblings, parents, children, grandparents and your Spouse's siblings and parents).
- Charges that would not have been made if you had no insurance.
- Charges for unnecessary care, treatment or surgery.

- To the extent that you or any of your dependents is in any way paid or entitled to payment for expenses by or through a public program, other than Medicaid.
- To the extent that benefits are paid or payable for expenses under the mandatory part of any auto insurance policy written to comply with a no-fault insurance law or an uninsured motorist insurance law. However, any adjustment option chosen under that part by you or any one of your dependents will be taken into account. In addition, if benefits are provided for that service under this Plan and any medical expense plan or prepaid treatment program sponsored or made available by your employer, benefits will be reduced so that the total payment will not be more than 100% of the charge made for the dental service.
- Sealants.
- Prosthesis over implants.

Vision Benefits

Vision Benefits provide coverage for eligible vision expenses for you and your covered dependents. Vision Benefits are administered by VSP.

For more information about your Vision Benefits, contact the Administrative Manager or VSP:

- Online at www.vsp.com; or
- By phone at (800) 877-7195.

Vision Network Providers

You may receive services from any qualified vision provider you choose, however, the Plan includes a network of vision providers through VSP, called the VSP Signature Network. The VSP Signature Network is a nationwide network of providers who have agreed to provide services at a discount to participants. This means that using network providers will lower your out-of-pocket costs.

A listing of network providers in the VSP Signature Network is available by calling VSP at (800) 877-7195 or online at www.vsp.com. When making your appointment, be sure to check that your provider participates in the network as providers change often.

How Your Vision Benefits Work

Here is how the Plan works:

- Review your benefit information before you make an appointment.
- Find a vision provider that is right for you.
- Make an appointment with your provider.
- If you go to a VSP provider:
 - When you go to your appointment, tell them you have VSP; no ID card is required.
 - Pay your copayment and any amount not covered by the Plan at the time of your appointment.
 - Your VSP provider will submit claims for any services they provide.
- If you go to a non-network provider:
 - The Plan pays benefits according to a fixed allowance, as shown in the [Summary of Vision Benefits](#) on page 30. You must pay your provider and then submit a claim to the Plan for reimbursement of covered expenses.

Summary of Vision Benefits

The following chart is intended as an overview; additional information is included in this section and is available by contacting VSP directly at (800) 877-7195.

Type of Expense	Frequency of Benefit Availability	VSP Signature Network Provider	Non-Network Provider
Well Vision Exam	Once every 12 months.	VSP pays 100% after you pay a \$5 copayment.	VSP reimburses up to \$50, any remaining balance is your responsibility.
<p>Prescription Glasses</p> <p>Lenses</p> <p>Frames</p>	Once every 24 months In lieu of contact lenses.	<p>VSP pays 100% after you pay a \$10 copayment.</p> <p><i>Lenses include single vision, bifocals and trifocals.</i></p> <p>VSP pays 100% up to a \$140 after you pay a \$10 copayment.</p> <p><i>You are eligible for 20% off any amount above the allowance.</i></p>	<p>VSP reimburses up to:</p> <ul style="list-style-type: none"> • \$50 for single vision • \$75 for bifocal • \$100 for trifocal • \$125 for lenticular <p>VSP reimburses up to \$70.</p>
Contacts	Once every 24 months in lieu of prescription glasses.	<p>VSP pays 100% up to a \$140 after you pay a \$10 copayment, evaluation exam and fitting.</p> <p><i>Current soft contact lens wearers may qualify for a special program that includes a contact lens exam and initial supply of lenses.</i></p>	VSP reimburses up to \$105 for elective contact lenses, evaluation exam and fitting; up to \$210 for necessary contact lenses, evaluation exam and fitting.

Vision Covered Expenses

Vision Benefits cover most routine eye care. Whether or not you use a network provider, here are some of the services and eyewear that are covered:

- **Eye Exam:** Complete initial vision analysis, which includes an appropriate examination of visual functions, including the prescription of corrective eyewear when indicated.
- **Lenses:** Spectacle lens coverage is designed to provide covered single vision, bifocal or trifocal lenses and professional services related to:
 - Prescribing and ordering proper lenses; and
 - Verifying the accuracy of finished lenses.
- **Frames:** A wide selection of frames is available.
- **Contacts:** Lenses needed to maintain your visual health are covered if bought instead of frames and lenses.

Additional Network Provider Discounts and Savings

When you go to a network provider, you are eligible for certain added discounts and savings, such as:

- Glasses and Sunglasses:
 - Average 35 - 40% savings on all non-covered lens options, like progressives and scratch-resistant or anti-reflective coatings;
 - 30% off additional prescription glasses and non-prescription sunglasses, including non-covered lens options, from the same VSP provider on the day you have your well vision exam; or
 - 20% off additional prescription glasses and non-prescription sunglasses, including non-covered lens options, from any VSP provider within 12 months of your last well vision exam.
- Contacts: 15% off the cost of contact lens exam, including fitting and evaluation.
- Laser Vision Correction: VSP has arranged for participants to receive discounted fees on specific laser vision correction surgeries provided at contracted facilities. Discounts vary by facility but will average 15% off the regular price. If the contracted facility is offering a temporary price reduction, VSP members will receive 5% off the promotional price. After surgery, you can use your frame allowance (if eligible) for sunglasses from any VSP provider.

Vision Limitations

This Plan is designed to cover visual needs, rather than cosmetic materials. If you select any of the following extras, the Plan pays the basic cost of the allowed lenses and you pay the additional costs for the following options:

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Scratch coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;
- Polycarbonate lenses;
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2;
- Progressive multifocal lenses;
- UV (ultraviolet) protected lenses;
- A frame that costs more than the Plan allowance;
- Contact lenses (except as specifically noted elsewhere as covered); and
- Certain low vision care.

Vision Exclusions

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a $\pm .50$ diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames provided under this Plan that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Any eye examination or any corrective eyewear required by an employer as a condition of employment.
- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK surgery.

Coordination of Benefits

Coordination of Benefits (COB) applies if you or a dependent are covered by more than one health plan, which includes medical, dental and vision plans. If coverage is provided under two or more plans, COB determines which plan pays first (is primary) and which plan pays second (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.

The Medical Plan is a Medicare Advantage Plan (Medicare Part C) providing medical and prescription drug benefits for retired participants and/or their dependents. This Plan complies with the rules of the Social Security Act of 1965, as amended. In general, this Plan is primary and will pay medical benefits first before any other plan (see exception below).

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 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.

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.

When Another Plan May Be Primary

If any eligible medical expense is payable by an individual Medicare plan, no payment will be made by this Plan.

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.

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.

When the Plan Needs Information to Coordinate

This Plan may need to disclose certain information to coordinate benefits with 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

As a Participant in the Plan, you have the right to appeal decisions to deny or limit Plan benefits. You may also file an appeal to address concerns regarding eligibility (your or a dependent's right to participate in the Trust).

The type of claim determines the way you appeal or ask for review of a denied or partially denied claim under the Plan.

If your claim involves eligibility to participate in the Plan or the application of other Plan rules, these claims and appeals procedures are explained in the section titled "Eligibility Claims and Appeals." You must submit these claims to the Plan's Administrative Manager. Final review of appeals from these claim denials is conducted by the Committee (or the designated subcommittee).

Examples of claims and appeals that must be submitted to the Administrative Manager or the Committee (or the designated subcommittee) would be an eligibility issue that resulted in a denial of a claim – for example, because a participant's spouse or child no longer meets the definition of dependent under the Plan.

If the claim concerns health care benefits, the claims procedures and appeal rights are explained in the section titled "Benefit Claims and Appeals".

Examples of appeals of health benefit decisions would be situations where the Plan denies your claim in whole or in part because the treatment is not medically necessary or is not a covered benefit or treatment under the Plan. Other examples might be a situation where the Plan denies part of a claim because the amount charged by the hospital or physician is greater than the amount the Plan has agreed to pay, or a prescribed drug is not one that the Plan covers.

If you want to make a claim or appeal a claim denial and you have a question as to whether your claim involves health benefits, or another type of claim contact the Administrative Manager.

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 of receipt of a complete claim for eligibility. 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.

Benefit Claims and Appeals

Benefit claims and appeals related to medical, dental and vision coverage.

You should carry your ID card(s) with you at all times, and present it when you go to your physician, hospital, clinic, dentist or other health care provider. Generally, the provider will submit your claim as indicated on your ID card. However, how the claim is paid may vary depending on if you use an in-network or non-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.
- **Non-Network Provider:**
 - If you receive treatment or services from a non-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 after you file a claim and you will be responsible for paying your provider.

Filing a Benefit Claim

If you need to file a claim yourself, contact your carrier (medical, dental or vision) at the toll-free customer service number on the back of your 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 Benefit 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.

Benefit Claim Determinations

Medical Benefits

There are several types of medical claims:

- **Urgent Care Claim:** An urgent care claim is any claim for medical care or treatment where using the regular timeframe for processing the claim either:
 - Could seriously jeopardize your life, 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.
- **Concurrent Care Claim:** 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.
- **Post-Service Claim:** A post-service claim is any claim that is not an urgent or concurrent care claim, as discussed above.

When you will be notified of a determination on your medical claim depends on the type of claim, as follows:

- **Urgent Care Claim:** 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 do 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 Claim:** You will receive 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.
- **Post-Service Claim:** You will be notified of a decision within a reasonable period, but not later than 30 days after receipt of your 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.

Other Benefits (Prescription Drug, Dental and Vision)

In general, all prescription drug, dental and vision benefit claims under the Plan are post-service claims. A post-service claim is a claim for benefits that occurs after the service, supply or treatment has been received.

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. The process for filing an appeal should be set forth in the notice of a denial on your claim.

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, you can call the toll-free customer service number on your ID card for information on filing all other appeals, or you can submit an appeal in writing to the appropriate Claims Administrator:

- For medical and prescription drug:
Blue Cross Blue Shield of Michigan
Grievance & Appeals Department
P.O. Box 2627
Detroit, MI 48231
Fax: (877) 348 2251
- For dental, you can call Cigna at (800) 244-6224 (select dental) and a customer service representative will assist you with your appeal. Or, you or your provider can send a written appeal to:
Cigna Dental Appeals
P.O. Box 188044
Chattanooga, TN 37422
- For vision:
Vision Service Plan (VSP)
Attn: Appeals Dept.
PO Box 2350
Rancho Cordova, CA 95741

Appeal Determinations

You will be notified of the decision on a(n):

- **Urgent care claim**, as soon as possible, taking into account the medical situation, but no later than 72 hours after receipt of your appeal; or
- **Post-service claim**, 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 Administrative Manager 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.

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.

Unclaimed Benefits

If any benefit payment to you from the Plan is unclaimed for a period of two years, it will revert to and become part of the Plan. Therefore, it is important for you to contact the Administrative Manager immediately if you lose a benefit payment.

Physical Examination

The Plan has the right to have you examined, at the Plan's expense by a licensed physician of the Plan's choosing, 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 to Medicare. 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 mandatory 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 Administrative Manager and Claims Administrators, is barred unless the complaint is filed within three years after the first date you receive a determination of your rights and/or benefits under the Plan, 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 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 ("PHI"). This notice gives you information regarding the uses and disclosures of PHI 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 PHI that they maintain on the Plan's behalf.

The Plan Privacy Officer can be contacted at:

UAW St. Joseph Retirees Health and Welfare Trust
c/o Derek Watkins
Watkins, Pawlick, Calati & Prifti, PC
1423 E. Twelve Mile Road
Madison Heights, Michigan 48071

How the Plan May Use and Disclose PHI

The following categories describe different ways that the Plan uses and discloses PHI. 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 PHI 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 PHI with a utilization review or precertification service provider. Likewise, the Plan may share PHI with another entity to assist with the coordination of benefit payments.
- **For Health Care Operations:** The Plan may use and disclose PHI for Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use PHI 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 PHI 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 PHI 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 PHI 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.
- **To Business Associates.** The Plan may disclose PHI to its business associates that perform functions on the Plan's behalf or provide the Plan with services if the information is necessary for such functions or services. For example, the Plan may use another company to perform billing services on its behalf. All of the Plan's business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in their agreement with the Plan.
- **When Legally Required:** The Plan will disclose PHI when it is required to do so by any federal, state or local law.
- **For Public Health Activities:** The Plan may disclose PHI 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.
- **For Reporting Abuse, Neglect or Domestic Violence.** The Plan may disclose your PHI when required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- **To Conduct Health Oversight Activities:** The Plan may disclose PHI 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 PHI 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 PHI 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 PHI.
- **For Law Enforcement Purposes:** As permitted or required by state law, the Plan may disclose PHI 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 PHI 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 PHI to organizations that handle organ procurement or transplantation.
- **For Research.** The Plan may disclose your PHI for research, subject to certain conditions regarding the manner in which the research is conducted.
- **In the Event of a Serious Threat to Health or Safety:** The Plan may disclose PHI 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 PHI 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 PHI to the extent necessary to comply with laws related to workers' compensation or similar programs.
- **For Other Purposes:** Other uses and disclosures of PHI 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 PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose PHI 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 PHI for other purposes not set forth in this Notice when the Plan is permitted to do so without your written authorization or consent.

- **Minimum Necessary Standard.** When using, disclosing or requesting PHI, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose. However, the minimum necessary standard will not apply in the following situations:
 - disclosures to or requests by a health care provider for treatment;
 - uses or disclosures made to the individual or pursuant to an authorization;
 - disclosures made to the Secretary of the U.S. Department of Health and Human Services;
 - uses or disclosures that are required by law; and
 - uses or disclosures that are required for the Plan's compliance with legal regulations.
- The Plan will not (1) supply confidential information to another entity for its marketing purposes in violation of the privacy regulations, or (2) sell your confidential information in violation of the privacy regulations.

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 PHI 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, with the exception of a request for a restriction of a disclosure of PHI pertaining solely to a health care item or service, for which the health care provider involved has been paid out of pocket, that is for purposes of carrying out payment or health care operations (and not for the purpose of carrying out treatment). 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 PHI by an alternative means or at an alternative location if a disclosure of your PHI 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.** If the information you request is in an electronic health record, you may request that these records be transmitted electronically. Your request for access to documents with your PHI 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 PHI, 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 PHI instead of your entire record, for a reasonable fee. You may also receive a copy of your PHI 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 PHI or for processing your request for access.) When a request for access is denied in part, the Plan will grant access to the PHI for which there are 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 PHI be amended if it is inaccurate or incomplete.** You may request that your PHI be amended. That request must be in writing to the Plan's Privacy Officer and include a reason why your PHI 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 PHI 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 PHI 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 PHI. 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 PHI unless you request the Plan do so. When the Plan is notified that your PHI 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 PHI of the amendment and require them to make the necessary corrections.

- **The right to obtain an accounting of disclosures of your PHI.** You have the right to request the Plan to provide you with an accounting of its disclosure of your PHI. 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 PHI;
 - 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.
- You also have the right to an accounting of disclosures of electronic health records for purposes of payment, treatment and health care operations. The right to such an accounting depends on whether the Plan maintains such electronic health records and, if so, when the electronic health records were acquired by the Plan and when the disclosure occurred.
- **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 PHI as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. If your PHI is improperly accessed, acquired, used, or disclosed, the Trust will notify you, as required by law. That notification may include a description of what happened, the information involved, and the steps you can take to protect yourself.

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 PHI 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.

Trust Privacy Officer

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

Trust Privacy Officer
UAW St. Joseph Retirees Health and Welfare Trust
c/o Derek Watkins
Watkins, Pawlick, Calati & Prifti, PC
1423 E. Twelve Mile Road
Madison Heights, Michigan 48071

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. In addition, the Plan itself may pursue a third party for recovery in the amount of benefits it has paid as a result of illness, injury, expense or loss caused by that third party.

By accepting benefits provided by this Plan, you (and your dependents, heirs or estate) 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.

The Plan will have a first priority lien on any recovery from a third party. This lien is binding on any attorney, insurance company, or other party who agrees or is obligated to make payment to you or your dependents as compensation for any damages. The lien exists at the time the Plan pays medical benefits. If you or your dependent files a petition for bankruptcy, you or your dependent agrees that the Plan’s lien existed in time prior to the creation of the bankruptcy estate.

If you have hired an attorney, and you and your attorney agree to honor the Plan’s first priority lien during any court proceedings, negotiations, or similar procedures, the Plan will consider reducing the amount of its recovery to allow for your attorney’s fees or court costs. To take advantage of this, you must have an express written authorization from the Plan or its representative.

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 or if you fail to repay the Plan, the Plan may offset future payments for medical services you receive by withholding payments until the entire amount due is reimbursed.

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 St. Joseph Retirees Health and Welfare Trust

Plan Name

UAW St. Joseph Retirees Health and Welfare Trust.

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 Administrative Manager.

The Committee is comprised of four independent members and three members appointed by the UAW.

The principal place of business for each of the Committee Members is

UAW St. Joseph Retirees Health and Welfare Trust

700 Tower Drive, Suite 300

Troy, MI 48098

Mailing Address:

P.O. Box 1708

Troy, Michigan 48099-1708

Administrative Manager

The Committee hired BeneSys, Inc. as the Administrative Manager. BeneSys handles general Plan administration, including eligibility, recordkeeping and inquiries. To contact BeneSys:

BeneSys

P.O. Box 1708

Troy, Michigan 48099-1708

(877) 941-4909 or (248) 641-4909

Fax: (248) 813-9898

Plan Sponsor Employer Identification Number (EIN)

27-1401289

Plan Number

501

Plan Year

The Plan Year is January 1 and ending December 31.

Plan Type

This Plan is a welfare benefit plan providing medical (including prescription drug), dental and vision coverage for Medicare-eligible participants.

Plan Funding

Benefits provided by this Plan are either fully insured, which means benefits are paid directly from an insurance company and are subject to the terms of the agreement with the insurance company, or self-funded, which means benefits are paid directly from the Trust out of its assets and no insurance company or other state licensed entity is responsible for financing the benefit, as follows:

- Medical and Prescription Drug Benefits are provided through a fully insured Medicare Advantage plan with Blue Cross Blue Shield of Michigan.
- Dental Benefits are self-funded but administered by Connecticut General Life Insurance Company (Cigna).
- Vision Benefits are self-funded but administered by VSP.

Agents for Service of Legal Process

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

UAW St. Joseph Retirees Health and Welfare Trust

c/o Derek Watkins
Watkins, Pawlick, Calati & Prifti, PC
1423 E. Twelve Mile Road
Madison Heights, Michigan 48071

Legal process also may be served on the Administrative Manager or on any Committee member at the office of the Administrative Manager.

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 Administrative Manager and Claims Administrators, is barred unless the complaint is filed within three years after the first date you receive a determination of your rights and/or benefits under the Plan, 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 (which include, but are not limited to, the Trust Agreement; certificates, riders, policies and schedules that form the basis of coverage with the insurance provider; policies of the Committee; and other contracts entered into by the Trust)

In the case of any uncertainty regarding the meaning or intent of any section in the Plan or Summary Plan Description, the interpretation of the Committee or the Committee'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 Bosch 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 Retired 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 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.

Notice of Nondiscrimination

The UAW St. Joseph Retirees Health & Welfare Trust (“Health Plan”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The UAW St. Joseph Retirees Health & Welfare Trust cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-941-4909.

ب قواذ بين الءقوق الءمذنية الء فءرالفة الءمعمول بءها ولا فم فمزلء أءساس الء عرق أو الء لون أو ehT
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1-877-941-4909ملءوءة: إذا ءنء ءءءء اءءر الءغة، فمء ءءمءء الءمساءءة الءلءوءفة ءءوافر لك بالءءان. اءصل برقم
4909

The UAW Saint Joseph Retirees Health & Welfare Trust erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-941-4909.

Whistleblower Policy

General

The Committee of the UAW St. Joseph Retirees Health and Welfare Trust (“Trust”) requires the Committee, the Trustee and service providers to observe high standards of business and personal ethics in the conduct of their duties and responsibilities in relation to the Trust.

This Whistleblower Policy is intended to encourage and enable individuals to raise serious concerns within the Trust prior to seeking resolution outside the Trust.

Reporting Responsibility

It is the responsibility of all Committee members, the Trustee and service providers to report ethics violations or suspected violations in accordance with this Whistleblower Policy. Participants will be encouraged to report suspected ethics violations.

No Retaliation

The Committee shall employ its best efforts to ensure that no person who in good faith reports an ethics violation shall suffer harassment, retaliation or adverse employment consequence. An individual who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment.

Reporting Violations

The Trust has an open-door policy and suggests that Committee members, the Trustee, and service providers share their questions, concerns, suggestions or complaints with someone who can address them properly. In most cases, the Trust’s Committee (the Plan Administrator) is in the best position to address an area of concern. However, if you are not comfortable speaking with the Committee, or are not satisfied with the response of the Committee, you are encouraged to speak with the Trust’s Compliance Office, Trust Legal Counsel, or any one of the Committee members whom you are comfortable in approaching.

The Committee, individual Committee members or Legal Counsel shall report all suspected ethics violations to the Trust’s Compliance Officer, who has specific and exclusive responsibility to investigate all reported violations. For suspected fraud, or when you are not satisfied or are uncomfortable with following the Trust’s open-door policy, you should contact the Trust’s Compliance Officer directly.

Compliance Officer

The Committee shall appoint a Compliance Officer. The Trust's Compliance Officer is responsible for investigating and resolving all reported complaints and allegations concerning violations and, at his/her discretion, shall advise the Committee. The Compliance Officer has direct access to the Committee and is required to report to the Committee at least annually on compliance activity.

Accounting and Auditing Matters

The Committee shall address all reported concerns or complaints regarding accounting practices, internal controls or auditing. The Compliance Officer shall immediately notify the Committee of any such complaint and work with the Committee until the matter is resolved.

Acting in Good Faith

Anyone filing a complaint concerning a violation or suspected violation should be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

Confidentiality

Suspected violations may be reported on a confidential basis or anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation.

Handling of Reported Violations

The Compliance Officer will notify the sender and acknowledge receipt of the reported violation or suspected violation within five business days. All reports will be promptly investigated and appropriate corrective action will be taken if warranted by the investigation.

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 as a result of 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.

Other Legal Protections

Newborns' and Mothers' Health Protection Act

Under federal law, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. The mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). You are not required to obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedemas. These benefits are provided the same as other benefits under the Plan.

Children's Health Insurance Program (CHIP) (if available in your state).

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage but need assistance in paying the health premiums.

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.

Glossary

Benefit Period

The period that starts the day you go into a hospital or skilled nursing facility and ends when you go 60 days in a row without hospital or skilled nursing care.

Calendar Year

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

Claims Administrator

The Claims Administrator is:

- Blue Cross Blue Shield of Michigan for medical and prescription drug claims;
- Cigna for dental claims; and
- VSP for vision claims.

Committee

The Committee that sponsors and administers the Plan.

Administrative Manager

BeneSys, Inc.
P.O. Box 1708
Troy, Michigan 48099-1708
(877) 941-4909 or (248) 641-4909
Fax: (248) 813-9898

Medicare

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

Plan or Fund

UAW St. Joseph Retirees Health and Welfare Trust.

Retired Employee

An individual who:

- Is eligible for Medicare due to age or disability;
- Was an hourly rated employee of Bosch's St. Joseph, Michigan Plant of the Chassis Systems Full Brakes, North America covered under collective bargaining between Bosch and the UAW covering the St. Joseph, Michigan plant: and
- Retired before January 1, 2010 with eligibility for pension benefits under the Bosch Braking Systems Pension Plan for Hourly Employees.

Surviving Spouse

An individual who was the Spouse of an hourly rated employee of Bosch's St. Joseph, Michigan Plant (Chassis Systems Full Brakes, North America) who died before January 1, 2010 and the deceased employee was eligible for Surviving Spouse coverage under this Plan at the time of death.

Important Phone Numbers

If You Have a Question About	You Should Contact
Eligibility	Trust Office: (877) 941-4909 Hours: 7:30 AM - 4:30 PM EST
Medicare Medical and Prescription Drug Coverage	Medicare Advantage BlueCross BlueShield of MI: (866) 684-8216 TTY - (800) 579-0235
Locating a Provider that Participates in the Blue Cross Blue Shield PPO Network	Blue Cross Blue Shield: (800) 810-Blue (2583)

Notes
