UAW HEALTH & WELFARE PLAN

QUICK REFERENCE GUIDE

EFFECTIVE: JANUARY 1, 2021

Important Notice: This is an outline of the principal plan provisions of the UAW Health and Welfare Plans and is not intended to completely describe the Plan provisions. In the event of any discrepancy between this outline and the Plans, the Plan Documents shall govern. For further information, please review your Summary Plan Description or contact the office of the Administrator, I. E. Shaffer & Co., at P. O. Box 1028, Trenton, NJ 08628. Telephone 1-800-792-3666.

UAW HEALTH & WELFARE PLAN

Effective November 1, 2018

ELIGIBILITY RULES

As a new employee, you will become eligible for coverage under the Welfare Plan beginning on the 1st day of the month for which a contribution is made on your behalf. Unless you opt-out of coverage (see below), you will automatically be enrolled in the Plan upon becoming enrolled for benefits.

ELIGIBILITY RULES – DEPENDENTS

1. Your spouse. The term spouse shall mean your legally recognized marital partner and except to the extent otherwise provided under the Fund documents. If you are married, the Fund office will require documentation proving a legal marital relationship. A divorce decree terminates the eligibility of a covered spouse (and step-children), regardless of any appeals from therefrom. If you fail to timely provide to the Fund Office a copy of your decree (and receive an acknowledgement from the Fund Office of that divorce decree), you will be responsible for all claims incurred relating to your spouse or ex-spouse after the required notification date.

2. The employee's biological child, stepchild, adopted child or child placed with you in anticipation of adoption who is under the age of 26 years of age.

3. You or your spouse's legal ward who: (a) resides with you in a regular parent-child relationship: and (b) is chiefly dependent on you for support and maintenance.

4. Your child who is mentally or physically incapable of earning his or her own living and providing his or her own support who attains the age of 26, provided you submit proof of the child's incapacity no later than January 31st each year and as otherwise required by the trustees and further provided that the child's handicap must have started before he or she reached age 26 and while the child was a covered Dependent under the Plan.

5. As required by the Federal Omnibus Budget Reconciliation Act of 1993, your child or step child who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan.

The Fund will require proof of dependent status.

WAIVER

If you are required to make an employee contribution in order to become eligible for coverage, you may opt-out of coverage (and may waive dependent coverage, if permitted by law). If you opt-out of coverage (or waive dependent coverage), you may only opt back in during open enrollment unless you (or your dependent) are eligible for special enrollment rights.

COBRA

If you fail to satisfy the above requirements and lose eligibility, you and your dependents may continue coverage under COBRA for up to 18 months (29 months if you are totally disabled and awarded Social Security Disabilty). If your dependent loses eligibility due to divorce or legal separation, or your child ceasing to satisfy the definition of an eligible dependent, they may continue coverage under COBRA for up to 36 months. The current monthly self-pay rates for the full plan under COBRA are:

Single	$ 647.27
Husband/Wife	$ 1078.77
Parent/Child(ren)	$ 1006.86
Family	$ 1438.36

This includes medical, prescription and vision coverage. There is no option to continue dental coverage.

TERMINATION OF COVERAGE

A Covered Employee's eligibility for benefits will automatically end at the earliest of the following dates:

- The last day of the month for which your Employer is required to make contributions to the Plan on your behalf (unless the applicable collective bargaining agreement or participation agreement provides a later date), or
- The date you cease to qualify for COBRA or Self-Pay, if permitted; or,
- The date the Plan is terminated; or,
- The date specified in a written notice from the Trustees to the Employers and the Union stating that the Benefit Programs for any Employer shall terminate on such date.

TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND

- **Core Benefits**
  - Hospital
  - Inpatient
  - Physical Therapy
  - Surgical
  - Outpatient
  - Diagnostic Testing
  - Transplant
  - Immunization and Injection
  - Major Medical
  - Prescription
  - Vision

- **Optional Benefits – only available if your employer and Union select the benefit**
  - Life Insurance
  - Accidental Death and Dismemberment
  - Dental/Orthodontia
  - Long Term and Short Term Disability

UAW HEALTH & WELFARE FUND

PLAN A

SCHEDULE OF BENEFITS

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY DIRECT ACCESS NETWORK

EFFECTIVE DATE: JULY 1, 2020

MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE		
(Calendar Year)		
Individual	$0	Not covered
Family	$0	Not covered
ANNUAL OUT-OF-POCKET MAXIMUM		
(Copays, deductibles, and coinsurance count towards this out-of-pocket limit). The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage. An individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum.		
Individual	$2,000	Unlimited
Family	$4,000	Unlimited
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Office Visit	100% after $25 co-pay	Not covered
Specialist Office Visit	100% after $25 co-pay	Not covered
Maternity Visits *maternity not covered for dependent children	100% after $25 co-pay (applies to 1st visit only)	Not covered

	IN-NETWORK	OUT-OF-NETWORK
PREVENTATIVE CARE (as defined by the Patient Protection and Affordable Care Act)		
	100% coverage	Not covered
DIAGNOSTIC PROCEDURES		
Laboratory	100% coverage	Not covered
Radiology	100% coverage	Not covered
HOSPITAL CARE		
Inpatient Admission	90% after $500 co-pay	Not covered
Inpatient Physician Services	90% coverage	Not covered
Surgery in Hospital	90% coverage	Not covered
Outpatient Hospital Services	90% coverage	Not covered
EMERGENCY CARE		
Emergency Room *This copay is waived if admitted	100% after $200 copay	100% after $200 copay
Ambulance *Covers transport from point where stricken to nearest hospital that can provide treatment	90% coverage	90% coverage
Urgent Care Center	100% after $25 co-pay	Not covered

	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT SURGERY		
Hospital Outpatient Surgery	90% after $100 co-pay	Not covered
Surgery in Ambulatory SurgiCenter	90% after $100 copay	Not covered
MENTAL HEALTH		
Office Visit	100% after $25 co-pay (in office or outpatient)	Not covered
Inpatient	90% after $500 co-pay	Not covered
*Inpatient requires pre-certification and includes intensive outpatient and sub-acute partial hospitalization		
SUBSTANCE/ALCOHOL ABUSE		
Office Visit	100% after $25 co-pay (in office or outpatient)	Not covered
Inpatient	90% after $500 copay	Not covered
*Inpatient requires pre-certification and includes intensive outpatient and sub-acute partial hospitalization		
OTHER SERVICES		
Chiropractic Care Visit *Up to 25 visits per person per calendar year	100% after $25 co-pay	Not covered
Home Health Care Services *No custodial care	90% coverage	Not covered
Hospice Services *10 day respite limit Excludes pastoral care and counseling.	90% coverage	Not covered
Skilled Nursing Care		
Inpatient	90% coverage	Not covered
Outpatient *Maximum 100 days per calendar year. Medical treatment only.	90% coverage	Not covered
Physical Therapy *Maximum 30 visits per calendar year	100% after $25 co-pay	Not covered

	IN-NETWORK	OUT-OF-NETWORK
Occupational Therapy *Maximum 30 visits per calendar year	100% after $25 co-pay	Not covered
Orthotics	100% after $25 co-pay	Not covered
Durable Medical Equipment	90% coverage	Not covered
Acupuncture	Not covered	Not covered
Bariatric Surgery	Not covered	Not covered
All Other Covered Medical Services	90% coverage	Not covered

Pre-Certification Requirements

All in-patient hospital stays must be pre-certified by **Horizon at 1-800-664-BLUE (2583)**. Emergency admissions must be certified within 72 hours after hospital admission. No benefits will be paid for treatment that is not pre-certified.

Prior Authorization Requirements

Effective July 1, 2020, all participants will need prior authorization for the following services/procedures:

a. **Diagnostic Radiology:**
   - Advanced Imaging (e.g. CT scan, CTA, CCTA, MRA, MRI, Nuclear Cardiac Imaging, Nuclear Medicine, PET, PET-CT Scans)
   - Primary Imaging (OB ultrasound, non-OB ultrasound)

b. **Musculoskeletal:**
   - Intervention Pain Management (e.g. Epidural Injections, Facet Joint Injections, Medial Branch Blocks, Interventional Pain Procedure Imaging, Monitored Anesthesia for Interventional Pain Procedures)
   - Spine Surgery (e.g. Decompressions and Fusions, Vertebroplasty/Kyphoplasty, Discectomy, Disc Anthroplasty)

c. Cardiology:

- Advanced Imaging and Diagnostic Services (e.g. Stress Test, Stress Echocardiogram, Echocardiography – thoracic and transesophageal, Diagnostic Heart Catherization, CT, MRI, Myocardial Perfusion Imaging – SPECT and PET,
- Implantable Device Services (e.g. Pacemaker, Implantable Defibrillator)

d. Radiation Therapy:

- External Beam Radiation Therapy
- Brachytherapy
- Intensity Modulated Radiation Therapy
- Image Guided Radiation Therapy
- Stereotactic Radiosurgery
- Proton Therapy
- Tomotherapy
- Radiopharmaceuticals

In addition to the pre-certification requirements above performed by Evicore, the following will require pre-certification by **Horizon**:

- Air Ambulance

In-Network Only

The medical coverage provided under the Plan is **in-network only**. The Plan does not provide out-of-network coverage for providers who do not participate in the HORIZON DIRECT ACCESS NETWORK. The only exception is "***emergency***" treatment rendered by an out-of-network provider with "***emergency***" defined as the sudden onset of an illness or injury where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

- Placing the covered person's life in jeopardy, or
- Causing other serious medical consequences, or
- Causing serious impairment to bodily functions, or
- Causing serious dysfunction of any bodily organ or part.

How to Find a Horizon Blue Cross Blue Shield of NJ Healthcare Provider

- Ask your physician, hospital, lab or other provider
- Horizon's website at www.horizonblue.com
- Call Horizon at 1-800-810-BLUE (2583)
- Call I.E. Shaffer & Co. at 1-800-792-3666

PRESCRIPTION DRUG BENEFIT
HORIZON/PRIME THERAPEUTICS

Retail Prescriptions*

(Mandatory generic substitution) –up to 30 day supply

Generic Drugs – $5 co-payment

Preferred Brand Name Drugs – 20% co-payment, $20 min. co-pay, $50 co-payment

Non-Preferred Brand Name Drugs – If no generic available: 30% co-payment, $35 min. co-pay, $75 max.co-pay. If generic available: $5 co-pay plus cost differential between brand name and generic

Specialty Drugs – 20% co-payment, min. $35 co-pay, max. $250 co-pay, up to $2,500 individual maximum out-of-pocket maximum

Mail Order and/or 90 Day Supply Retail Prescriptions*

(Mandatory generic substitution) –up to 90 day supply

Generic Drugs – $10 co-payment

Preferred Brand Name Drugs – 20% co-payment, $40 min. co-pay, $100 max. co-pay

Non-Preferred Brand Name Drugs – If no generic available: 30% co-payment, min. $70 co-pay, max. $150 co-pay. If generic available: $10 co-pay plus cost differential between brand name and generic

*After $500 per person or $1,000 per family of out-of pocket prescription expenses during a calendar year, there will be no co-payments required for the remainder of the year. If a name brand drug with a FDA approved generic is requested, the total co-pay will be the generic co-pay plus the difference in cost between the brand and generic medications. This penalty is not subject to the maximum co-pay limitations. The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage (an individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum).

Understanding the Prescription Drug Formulary

The drug formulary utilized by the Welfare Fund is a list of medications published by the Welfare Fund's Pharmacy Benefit Managers. Medications on the list fall into one of the four categories:

Generic Drugs – An FDA approved drug, composed of virtually the same chemical formula as a brand-name drug.

Preferred Brand Name - If a generic medication is not available for your condition, your doctor may prescribe a brand-name medication. Preferred Brand Drugs have been evaluated by physicians and pharmacists at the Pharmacy Benefit Manager and are deemed to be the most cost-effective way to treat a specific condition. These are covered at a slightly higher cost to you than generic drugs but at a lesser cost than the Non-Preferred Brand Drug.

Non-Preferred Brand Drugs - In the event you require a prescription medication that is neither generic nor on the Preferred Brand Drug list, you will pay the highest out-of pocket cost for a Non-Preferred Brand Drug.

Specialty Drugs – Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

DENTAL BENEFIT - HORIZON HEALTHY SMILES

Annual Deductible – $0

Coverage:

- Preventative & Diagnostic- 100%
- Basic Restorative – 80%
- Endodontics – 50%
- Periodontics – 50%
- Oral Surgery – 50%
- Prosthodontics – 50%
- Crowns – 50%
- Orthodontia – 50%

Annual Dental Maximum Benefit - $1,000 per person

Lifetime Orthodontic Maximum Benefit - $1,000 per person, covered up to age 19

VISION BENEFIT – DAVIS VISION

Covered once every calendar year

Eye examination -$0 in-network copay

Lenses - $10 in –network copay

Frame - $0 copay

- Covered in full frames: any fashion or designer level frame from Davis Vision's collection (retail value up to $160), or
- Frame allowance: $130 toward any frame from provider plus 20% off any balance, or
- Visionworks frame allowance: $180 allowance plus 20% off any balance toward any frame from a Visionworks retail store.

Contact Lens Evaluation, Fitting & Follow-Up Care

- Davis Vision Collection Contacts: Covered in Full
- Non Collection Standard Contacts: 15% discount
- Non Collection Specialty Contacts: 15% discount

Contact Lenses (in lieu of glasses)

- Covered in Full Contacts: up to 2 boxes planned replacement or 4 boxes of disposable, or
- Contact Lens Allowance: $130 toward any contacts from provider plus 15% off balance. Or
- Medically Necessary Contacts: covered in full with prior approval

WELFARE FUND BENEFIT PLAN MAXIMUMS

Annual In-Network Medical Maximum Out-of-Pocket Limit-$2,000 person/$4,000 family (Co-pays, deductibles and co-insurance count towards this out-of-pocket limit)

Annual Prescription Maximum Out-of-Pocket Limit - $500 person/$1,000 family (Prescription co-pays count towards this limit)

Chiropractic Care Maximum – 25 visits per person per benefit period

Dental Annual Maximum – $1,000 per person per calendar year

Hearing Aids – not covered

Home Health Care Maximum - no visit limit

Hospice Care Maximum – no visit limit, but has a limitation of 10 respite days

Infertility Treatment – 4 egg retrievals maximum. $5,000 lifetime maximum applies to IVF, GIFT and ZIFT

Lifetime maximum for surgical procedures performed to correct myopia (near sightedness) or hyperopia (far sightedness) – no coverage

Occupational Therapy Maximum– 30 visits per calendar year

Orthodontia- Lifetime Maximum - $1,000 up to age 19

Physical Therapy Maximum– 30 visits per calendar year

Skilled Nursing Care Maximum – 100 days per benefit period. Medical treatment only

Supplemental Speech Therapy Maximum – 30 visits per person per calendar year

UAW HEALTH & WELFARE FUND

PLAN B

SCHEDULE OF BENEFITS

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY DIRECT ACCESS NETWORK

EFFECTIVE DATE: JULY 1, 2020

MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE		
(Calendar Year)		
Individual	$500	Not covered
Family	$1,000	Not covered
ANNUAL OUT-OF-POCKET MAXIMUM		
(Copays, deductibles, and coinsurance count towards this out-of-pocket limit).		
The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage. An individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum.		
Individual	$2,000	Unlimited
Family	$4,000	Unlimited
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Office Visit	100% after $20 co-pay	Not covered
Specialist Office Visit	100% after $30 co-pay	Not covered
Maternity Visits	100% after $30 co-pay (applies to 1st visit only)	Not covered
*maternity not covered for dependent children		

	IN-NETWORK	OUT-OF-NETWORK
PREVENTATIVE CARE (as defined by the Patient Protection and Affordable Care Act)		
	100% coverage	Not covered
DIAGNOSTIC PROCEDURES		
Laboratory	90% after deductible	Not covered
Radiology	90% after deductible	Not covered
HOSPITAL CARE		
Inpatient Admission	90% after deductible	Not covered
Inpatient Physician Services	90% after deductible	Not covered
Surgery in Hospital	90% after deductible	Not covered
Outpatient Hospital Services	90% after deductible	Not covered
EMERGENCY CARE		
Emergency Room *This copay is waived if admitted	90% after $200 copay	90% after $200 copay
Ambulance *Covers transport from point where stricken to nearest hospital that can provide treatment	90% after deductible	90% after deductible
Urgent Care Center	100% after $20 co-pay	Not covered
OUTPATIENT SURGERY		
Hospital Outpatient Surgery	90% after deductible	Not covered
Surgery in Ambulatory SurgiCenter	90% after deductible	Not covered
MENTAL HEALTH		
Office Visit	100% after $30 co-pay (in office or outpatient)	Not covered
Inpatient *Inpatient requires pre-certification and includes intensive outpatient and sub-acute partial hospitalization	90% after deductible	Not covered

	IN-NETWORK	OUT-OF-NETWORK
SUBSTANCE/ALCOHOL ABUSE		
Office Visit	100% after $30 co-pay (in office or outpatient)	Not covered
Inpatient	90% after deductible	Not covered
*Inpatient requires pre-certification and includes intensive outpatient and sub-acute partial hospitalization		
OTHER SERVICES		
Chiropractic Care Visit	100% after $20 co-pay	Not covered
*Up to 25 visits per person per calendar year		
Home Health Care Services	90% after deductible	Not covered
*No custodial care		
Hospice Services	90% after deductible	Not covered
* 10 day respite limit Excludes pastoral care and counseling.		
Skilled Nursing Care		
Inpatient	90% after deductible	Not covered
Outpatient	90% after deductible	Not covered
*Maximum 100 days per benefit period. Medical treatment only.		
Occupational Therapy	100% after $30 co-pay	Not covered
*maximum 30 visits per calendar year		
Physical Therapy	100% after $30 co-pay	Not covered
Orthotics	100% after $30 co-pay	Not covered
Acupuncture	Not Covered	Not covered
Bariatric Surgery	90% after deductible	Not covered
All Other Covered Medical Services	90% after deductible	Not covered

Pre-Certification Requirements

All in-patient hospital stays must be pre-certified by **Horizon at 1-800-664-BLUE (2583)**. Emergency admissions must be certified within 72 hours after hospital admission. No benefits will be paid for treatment that is not pre-certified.

Prior Authorization Requirements

Effective July 1, 2020 all participants will need prior authorization for the following services/procedures:

e. Diagnostic Radiology:

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- Primary Imaging (OB ultrasound, non-OB ultrasound)

f. Musculoskeletal:

- Intervention Pain Management (e.g. Epidural Injections, Facet Joint Injections, Medial Branch Blocks, Interventional Pain Procedure Imaging, Monitored Anesthesia for Interventional Pain Procedures)
- Spine Surgery (e.g. Decompressions and Fusions, Vertebroplasty/Kyphoplasty, Discectomy, Disc Anthroplasty)

g. Cardiology:

- Advanced Imaging and Diagnostic Services (e.g. Stress Test, Stress Echocardiogram, Echocardiography – thoracic and transesophageal, Diagnostic Heart Catherization, CT, MRI, Myocardial Perfusion Imaging – SPECT and PET,
- Implantable Device Services (e.g. Pacemaker, Implantable Defibrillator)

h. Radiation Therapy:

- External Beam Radiation Therapy
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- Intensity Modulated Radiation Therapy
- Image Guided Radiation Therapy
- Stereotactic Radiosurgery
- Proton Therapy
- Tomotherapy
- Radiopharmaceuticals

In addition to the pre-certification requirements above performed by Evicore, the following will require pre-certification by **Horizon**:

- Air Ambulance
- Gastric Bypass Procedure(s)

In-Network Only

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PRESCRIPTION DRUG BENEFIT
HORIZON/PRIME THERAPEUTICS

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Generic Drugs – $5 co-payment

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Non-Preferred Brand Name Drugs – If no generic available: 30% co-payment, $35 min. co-pay, $75 max.co-pay. If generic available: $5 co-pay plus cost differential between brand name and generic

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WELFARE FUND BENEFIT PLAN MAXIMUM

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Lifetime maximum for surgical procedures performed to correct myopia (near sightedness) or hyperopia (far sightedness) – no coverage

Occupational Therapy Maximum – 30 visits per year

Orthodontia- Lifetime Maximum - $1,000 up to age 19

Physical Therapy Maximum – 30 visits per year

Skilled Nursing Care Maximum – 100 days per benefit period. Medical treatment only

Supplemental Speech Therapy Maximum – 30 visits per person per calendar year