UAW HEALTH & WELFARE PLAN

QUICK REFERENCE GUIDE

EFFECTIVE: JANUARY 1, 2022

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

- **MEDICAL – Horizon Blue Cross Blue Shield of NJ**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for member services

- **PRESCRIPTION – Prime Therapeutics/Horizon Blue Cross Blue Shield of NJ**
  - See following pages for plan information
  - Call Prime Therapeutics at 1-800-370-5088 for more information

- **BEHAVIORAL HEALTH – Horizon Blue Cross Blue Shield of NJ**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for member services

- **DENTAL– Horizon Blue Cross Blue Shield of NJ or Healthplex**
  - See following pages for plan information
  - Call Horizon at 1-800-433-6825 or Healthplex at 1-800-982-5529 for more information

- **VISION – Horizon Vista II (Horizon/Davis Vision View Network)**
  - See following pages for information
  - Call Horizon (Davis) Vision at 1-800-278-7753 for more information

- **Optional Benefits – only available if your employer and Union select the benefit**
  - Life Insurance
  - Accidental Death and Dismemberment
  - 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
Urgent Care Center	100% after $25 co-pay	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
*Inpatient hospital care requires prior authorization		
EMERGENCY CARE		
Emergency Room	100% after $200 copay	100% after $200 copay
*This copay is waived if admitted		
Ambulance	90% coverage	90% coverage
*Covers transport if emergent and medically necessary		

	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 prior authorization 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 prior authorization 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

Prior Authorization Requirements:

Benefits may be denied if prior authorization is not obtained for the below services:

For all **in-patient hospital** stays (both medical and behavioral health), providers must receive prior authorization from or Horizon Blue Cross Blue Shield **at least 24 hours prior to admission**. Emergency admissions must be authorized within 72 hours after hospital admission.

Radiology:

- Stress Testing: Myocardial Perfusion Imaging (SPECT and PET), Stress Echocardiography
- Echocardiography: transthoracic and transesophageal
- Diagnostic Heart Catherization
- Implantable Device Services: Pacemakers, Implantable cardioverter Defibrillator (ICD)
- Advanced Imaging: Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiograms (MRAs), Positron Emission Tomography (PET) scans, Positron Emission Tomography – computed tomography (PET-CT), Computed Tomography Angiography (CTA) scans, Nuclear Medicine and Nuclear Cardiac Imaging
- Primary Imaging: OB Ultrasound and Non-OB Ultrasound

Pain Management:

- Epidural Injections
- Facet Joint Injections
- Medial Branch Blocks

- Interventional Pain Procedure Imaging
- Monitored Anesthesia for Interventional Pain Procedures

Spine Surgery:

- Decompressions and Fusions
- Vertebroplasty/Kyphoplasty
- Discectomy
- Disc Arthroplasty

Radiation Therapy:

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

Specialty Pharmaceuticals

Medical Infertility Services*
**Providers must contact I.E. Shaffer @ 800-792-3666 for prior authorization*

In-Network Only

The medical coverage provided under the Plan is **in-network only**.

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your health plan's in-network cost sharing amount (such as copays and coinsurance). You can't be balance billed for any amount in excess of your in-network cost sharing amount for any emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for the services once you are stabilized. Out-of-network doctors, hospitals and other health care professionals are not permitted to seek your consent for the out-of-network services before providing the emergency services or during the time you are being stabilized.

Non-emergency services

When you get certain non-emergency services at an in-network hospital or ambulatory surgical center, certain providers at the facility may be out of network. Unless you give proper consent to get care from an out-of-network provider and waive your balance billing protections, the most an out-of-network provider may bill you is your health plan's in-network cost sharing amount. This applies but is not limited to such providers as anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. If proper consent is not provided, these providers can't balance bill you for their surprise services.

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

- Visit www.HorizonBlue.com and click Provider Directory. Look for Direct Access. If outside of NJ, use "provider outside of NJ" tab, go to Blue Card and click on "Start Search".
- Call I.E. Shaffer & Co. at 1-800-792-3666
- Confirm with your treating physician, hospital, lab or other provider prior to services

Horizon Care Navigator (Available to Active Employees and Non-Medicare Retirees)

If you have an acute or chronic condition, or need help understanding a new diagnosis, your dedicated Horizon Blue Cross Blue Shield Care Navigator, who is a **registered nurse**, can help by:

- Monitoring your medical situation and working with your doctors and caregivers to help manage your health needs
- Talking to you about your health and possible ways to improve it
- Connecting you with other health professionals, including registered dietitian and behavioral health specialist.

Participation in the program is free and voluntary. To speak with your Horizon Care Navigator, call **1-888-621-5894**, option **2**, followed by option **3** weekdays, between 8am and 5pm Eastern Time.

PRESCRIPTION DRUG BENEFIT
HORIZON/PRIME THERAPEUTICS

Retail Prescriptions*

(Mandatory generic substitution) –up to 30 day supply

- **Generic Drugs** – $5 co-pay
- **Preferred Brand Name Drugs** – 20% co-pay, $20 minimum co-pay, $50 maximum co-pay
- **Non-Preferred Brand Name Drugs** – If no generic available: 30% co-pay, $35 minimum co-pay, $75 maximum co-pay. If generic available: $5 co-pay plus cost differential between brand name and generic
- **Specialty Drugs** – 20% co-pay, minimum $35 co-pay, maximum $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-pay, 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 – Generic drugs are the un-branded form of a prescription medication. They use the same active ingredients as brand name drugs and work the same way. The FDA puts all generic drugs through a rigorous, multi-step process to ensure that they are the therapeutic equivalent of their brand name counterparts. That means that a generic drug can be substituted for a brand name drug, and it will produce the same clinical effect while meeting the same safety profile as the brand name drug.

Preferred Brand Name - These brand-name drugs have been identified as the most therapeutically safe and effective options for treatment of most medical conditions. These drugs do not have less-costly generic equivalents because they are sold under a trademarked name.

Non-Preferred Brand Drugs - These products often have either a generic equivalent or a preferred-brand drug alternative.

Specialty Drugs – Specialty pharmaceuticals is a class of prescription drugs that are typically produced through biotechnology (sometimes known as biologicals) and require special patient monitoring and handling, in addition also require unique education prior to use.

DENTAL BENEFIT

Two options:

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

OR

Healthplex

Annual Deductible - $0

Coverage:

- Preventative and Diagnostic – 100% (except sealants - $15 per tooth up to age 14)
- Basic Restorative – 100%
- Endodontics (including radiographs) – 100%
- Periodontics – 100% (except osseous surgery - $75 per quadrant)
- Simple Extractions – 100%
- Oral Surgery (including local anesthesia) – 100%
- Prosthodontics(including adjustments and relines for 6 months following installation) – 100%
- Crowns and Bridges – 100%
- Orthodontia – maximum 24 months of treatment (up to age 19) - $500 fee
  (Adult -19 years or older) - $1250 fee

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 *maternity not covered for dependent children	100% after $30 co-pay (applies to 1st visit only)	Not covered
Urgent Care Center	100% after $20 co-pay	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	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
*Inpatient hospital care requires prior authorization		
EMERGENCY CARE		
Emergency Room	90% after $200 copay	90% after $200 copay
*This copay is waived if admitted		
Ambulance	90% after deductible	90% after deductible
*Covers transport if emergent and medically necessary		
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	90% after deductible	Not covered
*Inpatient requires prior authorization and includes intensive outpatient and sub-acute partial hospitalization		

	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 prior authorization 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

PRIOR AUTHORIZATION REQUIREMENTS:

Benefits may be denied if prior authorization is not obtained for the below services:

For all **in-patient hospital** stays (both medical and behavioral health), providers must receive prior authorization from or Horizon Blue Cross Blue Shield **at least 24 hours prior to admission**. Emergency admissions must be authorized within 72 hours after hospital admission.

Radiology:

- Stress Testing: Myocardial Perfusion Imaging (SPECT and PET), Stress Echocardiography
- Echocardiography: transthoracic and transesophageal
- Diagnostic Heart Catherization
- Implantable Device Services: Pacemakers, Implantable cardioverter Defibrillator (ICD)
- Advanced Imaging: Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiograms (MRAs), Positron Emission Tomography (PET) scans, Positron Emission Tomography – computed tomography (PET-CT), Computed Tomography Angiography (CTA) scans, Nuclear Medicine and Nuclear Cardiac Imaging
- Primary Imaging: OB Ultrasound and Non-OB Ultrasound

Pain Management:

- Epidural Injections
- Facet Joint Injections
- Medial Branch Blocks
- Interventional Pain Procedure Imaging
- Monitored Anesthesia for Interventional Pain Procedures

Spine Surgery:

- Decompressions and Fusions
- Vertebroplasty/Kyphoplasty
- Discectomy
- Disc Arthroplasty

Radiation Therapy:

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

- Tomotherapy
- Radiopharmaceuticals

Specialty Pharmaceuticals

Medical Infertility Services*
**Providers must contact I.E. Shaffer @ 800-792-3666 for prior authorization*

IN-NETWORK ONLY

The medical coverage provided under the Plan is **in-network only**.

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your health plan's in-network cost sharing amount (such as copays and coinsurance). You can't be balance billed for any amount in excess of your in-network cost sharing amount for any emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for the services once you are stabilized. Out-of-network doctors, hospitals and other health care professionals are not permitted to seek your consent for the out-of-network services before providing the emergency services or during the time you are being stabilized.

Non-emergency services
When you get certain non-emergency services at an in-network hospital or ambulatory surgical center, certain providers at the facility may be out of network. Unless you give proper consent to get care from an out-of-network provider and waive your balance billing protections, the most an out-of-network provider may bill you is your health plan's in-network cost sharing amount. This applies but is not limited to such providers as anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. If proper consent is not provided, these providers can't balance bill you for their surprise services.

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- Call I.E. Shaffer & Co. at 1-800-792-3666
- Confirm with your treating physician, hospital, lab or other provider prior to services

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 minimum co-pay, $50 maximum co-pay
- **Non-Preferred Brand Name Drugs** – If no generic available: 30% co-pay, $35 minimum co-pay, $75 maximum co-pay. If generic available: $5 co-pay plus cost differential between brand name and generic
- **Specialty Drugs** – 20% co-pay, $35 minimum co-pay, $250 maximum 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-pay
- **Preferred Brand Name Drugs** – 20% co-pay, $40 minimum co-pay, $100 maximum co-pay
- **Non-Preferred Brand Name Drugs** – If no generic available: 30% co-payment, $70 minimum co-pay, $150 maximum 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

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Preferred Brand Name - These brand-name drugs have been identified as the most therapeutically safe and effective options for treatment of most medical conditions. These drugs do not have less-costly generic equivalents because they are sold under a trademarked name.

Non-Preferred Brand Drugs - These products often have either a generic equivalent or a preferred-brand drug alternative.

Specialty Drugs – Specialty pharmaceuticals is a class of prescription drugs that are typically produced through biotechnology (sometimes known as biologicals) and require special patient monitoring and handling, in addition also require unique education prior to use.

DENTAL BENEFIT

Two options:

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

OR

Healthplex

Annual Deductible - $0

Coverage:

- Preventative and Diagnostic – 100% (except sealants - $15 per tooth up to age 14)
- Basic Restorative – 100%
- Endodontics (including radiographs) – 100%
- Periodontics – 100% (except osseous surgery - $75 per quadrant)
- Simple Extractions – 100%
- Oral Surgery (including local anesthesia) – 100%
- Prosthodontics(including adjustments and relines for 6 months following installation) – 100%
- Crowns and Bridges – 100%
- Orthodontia – maximum 24 months of treatment (up to age 19) - $500 fee
  (Adult -19 years or older) - $1250 fee

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 MAXIMUM

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 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