HEALTH CARE PROGRAM

GENERAL INFORMATION

Overview

The General Motors Health Care Program for Hourly Employees (Health Care Program) provides comprehensive coverage for hospital, surgical, medical, behavioral health, prescription drug, dental and vision services received by eligible employees and dependents.

Services, supplies and prescribed medications necessary to treat medical and behavioral health conditions are covered under the Medical Plan. You will have the option to enroll in the Traditional Care Network (TCN) or in some regions, a Health Maintenance Organization (HMO) option. The TCN is offered nationwide regardless of where you live. Your choice of using an in-network provider (or network physician) or an out-of-network provider (or out-of-network physician) will normally determine how the Plan pays benefits. If you use a health care provider who participates in the TCN provider network, your share of the cost of medical care will generally be less than if you use an out-of-network provider. The TCN is administered by Blue Cross Blue Shield of Michigan.

Two HMO options are offered in Michigan (Blue Care Network HMO (BCN) and Health Alliance Plan HMO (HAP)) and one HMO option (MercyCare) is offered in certain zip codes in Wisconsin. HMOs are not offered outside of Michigan and Wisconsin. The HMO options require all care be provided or directed by your primary care physician (PCP) and you must use only those physicians and hospitals that participate in the HMO network or no benefits are payable, with the exception of emergency situations.

If you enroll in the Medical Plan, you will receive a GM health care ID card. When you receive medical services, always present your GM health care ID card to the provider. You may request additional cards at no cost by accessing your account through the *Carrier's* website or contacting the Carrier at the customer service number on the back of your GM health care ID card.

In addition to the Medical Plan, the Health Care Program gives you the option to enroll in coverage under the Dental and Vision Plans. You have the opportunity to elect benefit coverages that fit the needs of you and your family. You determine what value you will receive from your personal benefits package by choosing the Plans and coverage levels right for you.

Use this document as a guide to know what services are covered before you need to use them. Learn the meaning of common terms and become familiar with your coverage before a health care crisis occurs.

Eligibility

Employee

Traditional, In-Progression, and Full-Time Temporary employees are eligible for the Traditional Care Network and HMO medical plan options, along with dental and vision coverage on 1st day of employment.

Part-Time Temporary employees are eligible for coverage under the GM Temporary Employee Health Care Plan on 1st day of employment. **Part-Time Temporary employees** are not eligible for medical coverage under an HMO option, or dental and vision coverage.

Dependents

The following dependents are eligible to be enrolled in coverage.

Spouse
Your spouse who is legally married to you. Your spouse by common-law marriage is eligible for coverage if the laws of the state in which you reside recognize common-law relationships.

Dependent Children by Birth or Legal Adoption
Your dependent children, or your spouse's dependent children (i.e., your stepchildren), by birth or legal adoption are eligible for coverage through the end of the month in which they turn age 26, regardless of financial dependency, student status, employment, marital status, residency, or eligibility for other coverage.

Dependent Children by Legal Guardianship
If you are a legal guardian to a dependent child, they are eligible for coverage if **all** of the following criteria are met:

- Is a blood-relative to you or your spouse; and
- Has not reached the end of the month in which they turned age 26.

Dependent Children by Birth or Legal Adoption Who Are Totally and Permanently Disabled
Your biological or legally adopted child or stepchild is eligible for coverage beyond the end of the month in which they become age 26 if they are disabled and meet **all** of the following criteria:

- Became totally and permanently disabled **prior** to the end of the month in which the child turns age 26;
- Lives primarily with you or the other parent in a parent-child relationship; and
- Is unmarried.

Qualified Medical Child Support Order (QMCSO) or Medical Support Notice
Federal law requires the Plan to honor a Qualified Medical Child Support Order (QMCSO) and/or Medical Support Notice. In general, a QMCSO/Medical Support Notice is a state court order requiring an employee-parent to provide group health plan coverage (medical, prescription drug, dental and vision) to a dependent minor child, for example, in cases of legal separation or divorce. GM has no discretion and must comply with the terms of every duly authorized QMCSO/Medical Support Notice that it receives.

Information regarding enrollment pursuant to a Qualified Medical Child Support Order or Medical Support Notice can be obtained, without charge, by writing to the Plan Administrator at the, GM Benefits & Services Center, ATTN: QMCSO Processing, P.O. Box 770003, Cincinnati, OH 45277-0071, or by calling 1-800-489-4646.

No Double Coverage Permitted

You and your dependents cannot have double coverage under the GM Salaried and/or Hourly Health Care Programs. For example, if your spouse is also an eligible GM employee or retiree, you or your spouse may each be enrolled in coverage as an employee/retiree or one of you can be enrolled in coverage as the employee/retiree and the other as a dependent of the employee/retiree. You cannot be enrolled in coverage both as an employee or retiree, and as a dependent. Likewise, if you have an eligible dependent of two eligible employees/retirees (for example, both mother and father are employed and/or retired by GM; your eligible dependent can be covered by only one employee or retiree of GM.

Enrollment

Levels of Coverage

You may elect coverage for:

(1) Yourself only (single),

(2) Yourself plus your spouse,

(3) Yourself plus your child,

(4) Yourself and two or more children, or

(5) Yourself plus your spouse and your child(ren) (family).

Documentation Requirements for Enrolling Your Dependents to Your Coverage

As the primary enrollee, you will be asked to provide documentation necessary to substantiate the eligibility of enrolled dependents within thirty (30) days after receipt of the initial verification letter you receive, with a 15-day grace period. If documentation is not received by the designated deadline, the dependent will be removed from coverage on the first of the month following the end of the grace period (e.g., if the grace period ends on March 20, your dependents' coverage will end on April 1). If documentation is later provided, coverage in such cases will be reinstated retroactive to the date the dependent was originally enrolled (maximum of one year), following receipt of all required documentation.

For Spouse and Dependent Children: The documentation necessary for adding a spouse and dependent child(ren) and/or stepchildren must establish their relationship to you or your current spouse, such as a marriage certificate and birth certificates.

For Dependents by Legal Guardianship: The documentation necessary for adding a dependent by legal guardianship must establish blood relationship to you or your current spouse and legal documentation establishing the guardianship.

A note regarding dependents by legal guardianship: Health care coverage is effective the date guardianship becomes final as provided in the legal court documents, however a retroactive effective date is limited to twelve (12) months.

Ongoing Documentation Requirements: If you have dependents enrolled in coverage under the Program, you may be required to furnish documentation necessary to substantiate the continued eligibility of enrolled dependents (e.g., during a dependent verification audit).

If You are a New Employee or First Become Eligible

When you enroll in coverage, you may enroll in the Plans that best meet your family's needs. For example, enrollment in the Dental or Vision Plan is not dependent on your enrollment in the Medical Plan. You may elect to enroll in the:

- Medical Plan coverage alone,
- Medical Plan plus the Dental and/or Vision Plans for which you may be eligible,
- Dental and/or Vision Plan for which you are eligible only; or
- Waive all coverages.

When multiple medical plan options exist (e.g., TCN and HMOs), your enrollment option will apply to all enrolled dependents.

If you do not actively enroll in coverage when you first become eligible for coverage, you will automatically be enrolled in the TCN option with self-only (single) coverage.

Rolling Enrollment

Once enrolled, the health care enrollment process allows you to change your health care elections any time during the year. Once you have made a coverage option change, no further "elective changes" to that coverage will be permitted for the next twelve (12) months. Additional changes in coverage options are allowed, as exceptions to the 12-month waiting period, for *qualifying life events* (e.g., if you relocate, add or drop a dependent), for non-elective events (e.g., if you become enrolled for Medicare-primary coverage) or for mid-year changes in offerings.

The current calendar-year-based "Plan Year" continues and changes in options (e.g., adding new coverage options, dropping options, changing option benefit design features, etc.) are targeted to occur on January 1st of each year. If you change medical, dental or vision options during the year, you will have applicable calendar year maximums continued on a calendar year basis, with integration between Carriers.

See the *When Enrollment Changes Are Effective* section for more information.

If your coverage option is eliminated (for whatever reason) and you subsequently do not select another coverage option within the time period provided, you will be assigned to default coverages; however, you will be allowed to make subsequent prospective option selections without regard to the normal 12-month waiting period.

Special Enrollment and Qualifying Life Events

If you have declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Health Care Program if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). You must request enrollment per the terms of the Plan (see the Collective Bargaining Agreement)[2] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

[2] *When, as a result of oversight or error, an eligible primary or secondary enrollee entitled to coverage is not enrolled in a timely manner, coverage may be provided retroactive to the date of eligibility that would have been established if proper processing had occurred. However, in no event will the retroactivity exceed twelve (12) months from the month in which the error or omission is discovered. See Art. III, 9(a)(6) of Exhibit C-1.*

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Health Care Program, including the option of changing your medical plan option (e.g., TCN or HMO), if you are already participating. However, you must request enrollment per the terms of the Plan (see the Collective Bargaining Agreement)[2] after the marriage, birth, adoption, or placement for adoption.

When Enrollment Changes Are Effective

Changes in enrollment will be prospective and generally effective on the first day of the month after the GM Benefits & Services Center receives your request for enrollment changes. For example, if your enrollment change request is received on February 15, your requested changes will become effective on March 1. In the event the change is delayed, you will be informed of the effective date.

When Coverage Ends

Assuming you do not waive coverage under the Program, your coverage ends on the last day of the month in which:

- You no longer meet the eligibility requirements under the Health Care Program.
- Your employment with the Company terminates (see *Consolidated Omnibus Budget Reconciliation Act (COBRA)* section for more information.)
- You fail to pay required self-pay rates in certain situations.

Assuming you do not waive coverage under the Program, your dependents' coverage ends on the last day of the month in which:

- Your coverage ends.
- Dependent coverage is terminated.
- The individual is no longer an eligible dependent under this Program.

Explanation of Benefits (EOB)

An *Explanation of Benefits* (EOB) will be sent to you after your claim is processed. The EOB shows you what services have been rendered, the status of the claim and any payment made by either you or the Plan. It is not a bill. Please check this form carefully to make sure you received the services listed. It is very important that you notify the Plan's administrator (the carrier) if you did not receive the services outlined or if there are any discrepancies.

[2] *When, as a result of oversight or error, an eligible primary or secondary enrollee entitled to coverage is not enrolled in a timely manner, coverage may be provided retroactive to the date of eligibility that would have been established if proper processing had occurred. However, in no event will the retroactivity exceed twelve (12) months from the month in which the error or omission is discovered. See Art. III, 9(a)(6) of Exhibit C-1.*

Health Care Tips

The cost of health care affects everyone. That's why it is important that each of us takes an active part in keeping health care affordable. Following these tips will help to reduce health care costs:

Use in-network providers: In-network providers have chosen to work closely with GM's *Carriers* to help hold down rising health care costs. When you choose to receive services and supplies from in-network providers, you can reduce your own out-of-pocket expenses and support the Program's efforts to keep health care affordable.

Select a primary care physician (PCP): It is important to have one physician that you see on a regular basis. Most people use either a family practitioner, an internist, or pediatrician as their personal physician or "family doctor." Let your physician get to know you, your medical history, and your lifestyle. Your PCP can then take care of you for regular check-ups, refer you to specialists when necessary, help you manage chronic conditions, and coordinate your hospital care. Be sure to select a physician who makes you feel comfortable and whose specialization meets most of your day-to-day health care needs.

Understand your health care benefits: Know what services are covered before you need to use them, and whether the provider you are receiving services from is in-network. Learn the meaning of terms such as deductible, copayment (copay), coinsurance and out-of-pocket maximums. Become familiar with your coverage before a health care crisis occurs and learn about the most appropriate places for care when you need it. Utilize the assistance of your local Union Benefit Representatives (UBRs) where appropriate.

Ask questions: Feel free to ask your provider questions. It is important to know how much office visits cost if recommended tests are necessary or if a prescribed medication has possible side effects. Always insist all your questions are answered and be sure to discuss all your treatment options with your provider so you can make informed decisions.

Use your benefits efficiently: The best health care isn't always the most expensive care. For example, you may want to see a doctor virtually or use an urgent care center or walk-in clinic, versus an emergency room when your symptoms are not life-threatening.

Stay healthy: The best way to protect your health is to live a healthy lifestyle. Use good sense in maintaining a balanced diet, exercising regularly, wearing your seat belt, and avoiding tobacco and alcohol misuse. Pay attention to the warning signs your body gives you. When you follow good health rules, you avoid habits and activities that put you at risk for disease and injury.

Look over your health care bills: Doctors' offices and hospitals can make mistakes, so it's smart to look at your bills closely. Make sure you aren't billed for services you didn't receive. If you find an error, inform your provider or hospital right away. Utilize the assistance of your local Union Benefit Representatives (UBRs) where appropriate.

Help prevent fraud: Each year, health care fraud costs employers and employees, so it is important to check your bills and explanation of benefits statements to make sure you received the services listed.

Common Terms

Ambulance Services – Medically necessary transportation and life support services provided to sick, injured, or incapacitated patients by a licensed ambulance provider, utilizing ambulance vehicles and personnel recognized as qualified to perform such services at the time and place where rendered.

Approved Amount – The maximum amount on which payment is based for covered health care services by carriers, plan administrators, preferred providers or similar organizations to reimburse participating or network providers for covered services or the actual amount charged by the provider if less than the maximum. Other common terms used for *approved amount* may be "eligible expense," "payable allowance," "reasonable and customary amount," "allowed amount," "negotiated rate," or "payment allowance." *The Plan/Collective Bargaining Agreement refers to the Approved Amount as the Allowed Amount.*

Balance Billing – When a provider bills you the difference between the total charged for a health care service and the approved amount. For example, if the provider's charge is $100 and the approved amount is $70, the provider may bill you for the remaining $30, in addition to any cost-sharing (deductible and/or coinsurance) responsibilities. A preferred or in-network provider must accept approved charges as payment in full and may *not* bill you for covered services in excess of the approved amount.

Benefit Period – A period of time during which you or an enrolled dependent is entitled to receive certain covered services that are subject to Health Care Program maximums.

Carrier – Any entity by which the various health plans (medical, pharmacy, behavioral health, physical therapy, hearing aids, dental and vision) are administered or benefits paid. Examples of Carriers for purposes of this Program are Blue Cross Blue Shield of Michigan, CVS Caremark, AudioNet, Delta Dental of Michigan, Davis Vision, etc.

COBRA – *Consolidated Omnibus Budget Reconciliation Act of 1985*; Federal legislation providing continuation rights to certain employees or dependents whose coverage under company-sponsored Programs is lost due to certain "qualifying events."

Coinsurance – Your share of the costs of a covered health care service, usually a percentage (for example, 10%) of the approved amount for the service. (For example, if the approved amount for a covered service is $100 and you have met your deductible, your coinsurance payment of 10% would be $10. The Plan pays the remaining portion of the approved amount, or $90.)

Copayment (Copay) – A set dollar amount you pay for a health care service or prescription, usually when you receive it.

Core Coverage – Under the Health Care Program, benefits are paid for hospital, surgical, medical, prescription drug and hearing aid services as set forth in Appendix A, and behavioral health and substance use disorder treatments as set forth in Appendix B, of Exhibit C to the Supplemental Agreement (Exhibit C). Collectively, these coverages shall be referred to as the Medical Plan throughout this document.

Covered Expense – The approved amount incurred for covered materials and services provided or rendered to or for an enrollee for treatment of illness or injury, and performed by a provider or prescribed by a physician in accordance with the provisions of the Health Care Program.

Covered Service – A service that is included within the range of services identified in the Program, and that meets all Health Care Program requirements to be eligible for payment of benefits. A service within the range of those identified in the Health Care Program (e.g., a diagnostic radiology service), but does not meet all the specifications to be eligible for coverage (e.g., medically necessary) is considered a non-covered service.

Custodial or Domiciliary Care or Services – Non-medical care or assistance to help an individual with activities of daily living (ADL), such as bathing, dressing, eating, etc. Care may be recommended by a licensed provider, but the provider of the care itself is not required to be a medical professional (for additional clarification, refer to App. A. 1.F. of the Supplemental Agreement (Exhibit C)).

Deductible – The amount you *could* owe during a coverage period (for the Health Care Program, January 1 – December 31) for covered health care services before your Plan begins to pay. For example, if your deductible is $250, your Plan will not pay for covered expenses until you have met your $250 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Diagnostic Services – Tests and evaluations ordered by a doctor or health care professional to determine the cause of symptoms related to a specific condition, illness or injury.

Durable Medical Equipment (DME) – Equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally useful to an enrollee in the absence of illness or injury.

Emergency Room Services and Observation Care – Services delivered in the emergency department of a hospital are covered for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

ERISA – The *Employee Retirement Income Security Act of 1974*, is a federal law that sets standards of protection for individuals provided private-sector health care, defined contribution and defined benefit plans.

Freestanding Ambulatory Surgical Center (ASC) – A modern health care facility focused on providing same-day surgical care on an outpatient basis, including diagnostic and preventive procedures. Such facilities must meet Health Care Program standards and be approved by the Carrier for services to be eligible for coverage.

GM Benefits & Services Center – A service center through which GM employees, retirees and surviving spouses may obtain services regarding their benefits. The GM Benefits & Services Center processes various benefit-related transactions, provides general benefit-related information and assists with problem resolution. They also provide services regarding account information and transactions under the Personal Savings Plan, and benefits under the Pension Plan. Their website is **gmbenefits.com**.

Health Maintenance Organization (HMO) – A type of plan where you need to get a referral from your primary care provider before seeing a specialist. If enrolled in an HMO, you must generally use HMO providers and facilities in order to receive benefits.

HIPAA – *Health Insurance Portability and Accountability Act of 1996*; Federal legislation intended to improve the availability and portability of health care coverage, which requires employers to provide a certificate of prior health care coverage when an enrollee loses coverage.

Home Health Care (HHC) – Care or services provided in the home for a patient who is essentially homebound, but whose condition does not warrant care in an institutional setting (such as a hospital or skilled nursing facility). The care/service is generally skilled, part-time and intermittent in nature.

Hospice Program, including Pre-Hospice Programs – Medical and non-medical services provided for terminally ill enrollees and their families through agencies which administer and coordinate the services. A hospice program must meet Health Care Program standards and be approved by the Carrier for services to be eligible for coverage.

In-Network Provider – Any hospital, skilled nursing facility, outpatient physical therapy facility, home health care agency, physician, dentist, or other provider of health care services who meets Program standards and has entered into a contract or agreement with a Carrier to provide health care services in accordance with this Program. Such contract or agreement shall include a provision that the provider accepts the approved amount for covered expenses, as determined by the Carrier, as payment in full (unless otherwise provided).

Inpatient Behavioral Health Care – Mental health or substance use disorder treatment received in a hospital, detoxification facility, or residential care facility.

Intermittent Care – Part-time care that is provided on less than a daily basis or up to eight hours per day of skilled nursing and home health aide services combined, delivered on a daily basis, but for a temporary period not to exceed one month.

Medical Emergency – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- Acute symptoms must occur suddenly and unexpectedly.
- Care must be secured within 72 hours of the onset of the condition.
- The condition must be of such a nature that severe symptoms occur suddenly and unexpectedly and that failure to render treatment immediately could result in significant impairment of bodily function, cause permanent damage to the enrollee's health, or place such enrollee's life in jeopardy.
- The signs and symptoms demonstrated by the patient at the time of treatment, as verified by the physician, and not the final diagnosis must confirm the existence of a threat to life or bodily functions.

Non-Core Coverages – Under the Health Care Program, benefits paid for dental (Appendix C) and vision (Appendix D) services as set forth in the Supplemental Agreement (Exhibit C). Collectively, these coverages shall be referred to as the Dental Plan and Vision Plan throughout this document.

Orthotic Appliance – An external device intended to correct any defect of form or function of the human body.

Out-of-Pocket Maximum – The most you'll have to pay during a Plan Year for covered health care services you receive. Your out-of-pocket maximum includes your deductible, copay, and coinsurance.

Outpatient Behavioral/Mental Health Facilities – Governmental, public, private, or independent unit facility or treatment centers providing outpatient behavioral health counseling/therapy/substance use disorder services in an ambulatory care setting to care for adults or children, such as a hospital unit, clinic or partial hospitalization treatment center.

Part-Time Care – Up to and including 28 hours per week of skilled nursing and home health aide services combined, for less than eight hours per day; or up to 35 hours per week for less than eight hours per day, subject to individual review and approval by the Carrier.

Physical Therapy and/or Functional Occupational Therapy – Therapy directed toward improving or restoring the level of musculoskeletal function lost due to illness or injury, the development of new function attainable following surgery, or, if for a chronic or congenital condition, significantly improving the condition in a reasonable and predictable period of time. Physical therapy generally pertains to large muscle use and functional occupational therapy to fine motor activities.

Physician – A Doctor of Medicine (M.D.) or Osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform surgery at the time and place services are rendered or performed. As used herein, physician shall also include the following categories of limited-practice professionals who are legally qualified and licensed to practice their specialties at the time and place services are performed, and who render specified services they are legally qualified to perform:

- **Dentist** means a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) whose scope of practice is the diagnosis, prevention, and treatment of disease of the teeth and related structures.
- **Podiatrist** means a Doctor of Podiatric Medicine (D.P.M.) or a Doctor of Surgical Chiropody (D.S.C.) whose scope of practice is the diagnosis, prevention and treatment of ailments of the feet. Services of podiatrists, relating to the foot (including the ankle), may be covered under the surgical and medical coverage. A podiatrist also may prescribe medications that may be covered under the prescription drug coverage.
- **Chiropractor** means a Doctor of Chiropractic (D.C.) whose scope of practice is the diagnosis and treatment of subluxation or misalignments of the spinal column and related bones and tissues that produce nerve interference. Services of chiropractors that may be covered are limited to diagnostic radiological services and chiropractic spinal manipulation (CSM) and chiropractic manipulation (CM) as set forth in Appendix A, III, M. Under the Health Care Program, a chiropractor may not prescribe medications or perform invasive procedures or incisive surgical procedures, provide outpatient physical therapy services, nor perform physical examinations not related to the spine and related bones and tissues.
- **Optometrist** means a Doctor of Optometry (O.D.) whose scope of practice is the examination, diagnoses, treatment, and management of diseases, injuries, and disorders of the visual system, the eye, and associated structures as well as to identify related systemic conditions affecting the eye. Services of optometrists which may be covered per local plan policies are limited to routine eye examinations, any other services performed by an optometrist are not covered.
- **Psychologist** means a health care professional with a clinical or counseling doctoral degree of psychology (Ph.D.). Certain services of a psychologist may be covered under the Program when performed in response to a medical diagnosis and when Program standards are met.

Plan Year – A 12-month period of benefits coverage. For purposes of the Health Care Program, the Plan Year is January 1 through December 31.

Precertification – Approval required for a health care service before you receive it, so that the Program will pay benefits for treatment. Also sometimes referred to as *predetermination (as defined in the CBA), prior authorization,* or *pre-approval.*

Preferred Provider Organization (PPO) – A type of plan where you don't need to get a referral from your primary care provider to see a specialist, and that may offer more flexibility in choosing providers, specialists and facilities. PPO enrollees must use PPO physicians and facilities in order to receive the maximum benefit under the Program.

Pre-hospice – Refers to an initial level of hospice care consisting of evaluation, consultation and education, and support services that may be used prior to a terminally ill enrollee's election of hospice coverage. A pre-hospice program must meet Health Care Program standards and be approved by the Carrier.

Preventive Service – Tests or other health care services *(as defined in the CBA)* intended to prevent diseases or conditions at an early stage when treatment is likely to work best.

Primary Plan – Refers to the health care plan responsible to pay first when the covered person has coverage under more than one plan.

Prosthetic Appliance – An artificial device that replaces an absent part of the body, or which aids the performance of a natural function of the body without replacing a missing part.

Provider – A person (such as a doctor) or a facility (such as a hospital) that provides health care services. Providers are considered to be in-network when they have signed an agreement with the Carrier to accept as "payment in full" the amount which the Carrier determines to be an appropriate charge for services rendered. You should use in-network providers whenever possible to limit the likelihood of personal liability for charges in excess of the Carrier's payment.

Reasonable and Customary Charge – As it relates to covered health care expenses, unless otherwise specified, means the actual amount a provider charges for such services rendered or materials furnished, but only to the extent that the amount is reasonable, as determined by the Carrier, taking into consideration, among other factors, the following:

- The usual amount that the individual provider most frequently charges the majority of patients or customers for a similar service rendered or materials furnished.
- The prevailing range of charges made in the same geographic area by providers with similar training and experience for the service rendered or materials furnished.
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with the particular service rendered or materials furnished.

The Carrier is responsible for determining the appropriate reasonable and customary charge for a given provider, service, or material. The Carrier shall have discretionary authority to interpret, apply, and construe this provision of the Health Care Program. The determination by the Carrier as to the reasonable and customary charge shall be final and conclusive, and shall be given full force and effect unless it is determined by the Program Administrator to have been contrary to the Health Care Program provisions or it is proven that the determination was arbitrary and capricious.

As used in the Health Care Program, reasonable and customary also refers to the forms and/or amount of payment used by Carriers and network providers or similar organizations to reimburse participating or contracted providers for covered services.

Secondary Plan – Refers to the health care plan that has the secondary obligation to pay benefits when more than one plan covers an individual.

Skilled Nursing Care – Care or services that are prescribed by a physician and furnished by a Licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN). The services may be provided on a continuous (as in a hospital or skilled nursing facility) or on an intermittent/part-time basis. The patient must be under treatment and/or convalescing from an illness or injury that requires ongoing evaluation and adjustment of care. The nature of the service and skills required for safe and effective delivery, rather than the patient's medical condition, determines whether the service is skilled.

Skilled Nursing Facility (SNF) – A facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a physician and a registered nurse. The facility may be operated either independently or as part of an accredited general hospital. A skilled nursing facility must meet Health Care Program standards and be approved by the Carrier for services to be covered.

Spouse – An individual who is lawfully married to another individual, including by common-law marriage only to the extent such relationship is recognized by the laws of the state in which the individual resides (refer to Article III, 9(b) of the Supplemental Agreement (Exhibit C) for further clarification).

Subrogation – The process of recovering payment when another person, insurance company or organization may be legally obligated to pay for health care services that a carrier has already paid; for example, in the case of a court judgment.

Surviving Spouse Coverage – Where applicable, provides benefits for your eligible spouse in the event that you die before your spouse.

Therapeutic Care – Specific and definitive surgical, medical, psychiatric, or other care provided to a patient whose condition continues to improve due to the treatment being received. It is provided with the expectation that the patient's level of disability will be reduced, within a reasonably predictable period of time, to enable the patient to function without such care. The improvement must be observable and documented by objective measurement. If a patient's condition stabilizes and further improvement is not reasonably predictable, continuing care will be considered maintenance care in nature.

Utilization Review Organization – An organization retained to perform certain utilization review and utilization management functions, including predetermination, concurrent and retrospective utilization review.

MEDICAL PLAN (CORE COVERAGE)

Medical Plan Options

Based on your employee status and your address of record, you may be offered a choice of medical plan options, to the extent they are available in your area, as follows:

- The Traditional Care Network (TCN) Preferred Provider Organization (PPO) option
- Health Maintenance Organization (HMO) option, where available

The options are designed to provide you and your eligible family members high-quality health care. Descriptive materials concerning benefits provided under each option are available through the GM Benefits & Services Center. Although coverages may differ slightly under the various options, in general, covered expenses include the items detailed below. This is a general description only and the provisions of the Program control your eligibility for coverage and specific benefits.

Common Terms are defined in the *General Information* section.

GM Traditional Care Network and HMO Medical Plans and Cost-Sharing At-A-Glance (for Traditional, In-Progression and Full-Time Temporary Employees)

The chart below compares what you pay and what the Program pays depending on the medical plan option in which you enroll. Please note that prescription drug copayments may be adjusted on an annual basis.

	Traditional Care Network PPO	HMO (in select regions)
In-Network and Out-of-Network Deductible	None	None
In-Network Care (Coinsurance)[4]	Many services covered at 100%	Many services covered at 100%
Out-of-Network Care (Coinsurance)[5]	Many services covered at 90%, you pay 10%	Not covered (except in emergencies)
In-Network Annual Out-of-Pocket Maximum	None	HAP HMO: $8,150 single / $16,300 family MercyCare: $8,150 single / $16,300 family BCN HMO: $6,350 single / $12,700 family
Out-of-Network Annual Out-of-Pocket Maximum	$250 single / $500 family *(**Note:** Copays for office visits, emergency room, urgent care and prescription drugs are not applied to annual maximum)*	Not applicable
In-Network Office Visits[6]	$25 copay per visit (in-network only)	$25 copay per visit (in-network only) *HAP HMO and MercyCare: Referrals are not required by primary care physician for specialist care as long as the specialist is in-network* *BCN HMO: Referrals required by primary care physician for specialist care*

	Traditional Care Network PPO	HMO (in select regions)
Out-of-Network Office Visits[6]	$25 copay per visit; referral required for office visits to be covered for an out-of-network provider (otherwise not covered)	Not covered
Chiropractic Visits	$25 copay per visit; limited to a combined maximum of 24 manipulation visits per calendar year	HAP HMO: $25 copay per visit; limited to a combined maximum of 24 manipulation visits per calendar year MercyCare: $25 copay per visit; unlimited visits BCN HMO: $25 copay per visit; unlimited visits, when referred
Emergency Room Visits[6]	$100 copay per visit, waived if admitted	$100 copay per visit, waived if admitted
Telehealth Visits[6]	$12.50 copay per visit	HAP HMO: $12.50 copay per visit MercyCare: $12.50 copay per visit BCN HMO: $12.50 copay per visit
Urgent Care Visits[6]	$50 copay per visit	$50 copay per visit
Prescription Drugs[6] *(in-network retail pharmacies)*	$6 generic $12 brand name $17 erectile dysfunction	$6 generic $12 brand name $17 erectile dysfunction[7]
Prescription Drugs[6]	*Select participating retail pharmacies, or through Caremark Mail-Order Service* $12 generic $17 brand name $21 erectile dysfunction	*90-supply fill using the HMO mail-order pharmacy service:* $12 generic $17 brand name $21 erectile dysfunction[7]
Preventive Services and Drugs	Baby/child/adult routine exam annually covered at 100% when received in-network. Certain prescription and OTC meds (aspirin, fluoride prep, smoking deterrents, folic acid preparations, prescription contraceptives) require a prescription and must be dispensed by a participating pharmacy to be covered at 100%.	Baby/child/adult routine exam annually covered at 100% when received in-network. Certain prescription and OTC meds (aspirin, fluoride prep, smoking deterrents, folic acid preparations, prescription contraceptives, vitamin D supplementation) require a prescription and must be dispensed by a participating pharmacy to be covered at 100%.

	Traditional Care Network PPO	HMO (in select regions)
Inpatient Behavioral Health Services and Substance Use Disorder Treatment	**In-Network:** Covered 100% up to 365 days, renewable after 60 days of non-confinement. **Out-of-Network:** Covered 90% up to 365 days, renewable after 60 days of non-confinement. You pay 10% coinsurance up to the Out-of-Pocket Maximum (OOPM). Services subject to Plan cost-sharing provisions (deductibles and coinsurance).	**Inpatient Behavioral Health:** Covered 100% when authorized by HMO **Inpatient Substance Use Disorder:** Covered 100% when authorized by HMO
Outpatient Behavioral Health Services and Substance Use Disorder Treatment ***received in a clinical setting***[9]	**In-Network Behavioral Health:** **Visits** **You Pay**[9] 1-20 $0 21-35 25% *(up to a maximum of $25)* 36+ $25 copay **In-Network Substance Use Disorder:** **Visits** **You Pay**[9] 1-35 $0 36+ $25 copay **Out-of-Network Behavioral Health:** Reimbursed at 50% for treatment received from an M.D. or D.O.[8] **Out-of-Network Substance Use Disorder:** No coverage, except in the case of an emergency, subject to certain conditions, in which case treatment is covered in full (see App. B, III. E. 2. b. (2)(b)).	**Outpatient Behavioral Health:** Covered 100% when authorized by HMO **Outpatient Substance Use Disorder:** Covered 100% when authorized by HMO

	Traditional Care Network PPO	HMO (in select regions)
Outpatient Behavioral Health Services and Substance Use Disorder Treatment ***received in a virtual setting***	**In-Network Behavioral Health:** **Visits** **You Pay** 1-20 $0 21-35 12% *(up to a max. of* **$12.00)** 36+ $12.00 copay **In-Network Substance Use Disorder:** **Visits** **You Pay** 1-35 $0 36+ $12.00 copay **Out-of-Network Behavioral Health:** No coverage **Out-of-Network Substance Use Disorder:** No coverage	**Outpatient Behavioral Health:** Covered 100% when authorized by HMO **Outpatient Substance Use Disorder:** Covered 100% when authorized by HMO

[4] *Covered services received in-network are paid at 100% of the amount the Plan allows for payment for the covered service. For the Traditional Care Network, if necessary, predetermination approvals for certain services are not obtained, services are payable at 80% of allowed charges after the first $100 of expense, up to a maximum out-of-pocket charge of $750 individual, $1,500 family.*

[5] *Covered services received from out-of-network providers are paid at 90% of the amount the Plan allows for payment of the covered service. Charges above the amount allowed by the Plan may be the responsibility of the enrollee.*

[6] *Not applied to out-of-pocket maximum accumulators.*

[7] *Not covered if enrolled in MercyCare HMO.*

[8] *If outpatient behavioral health services are rendered by an out-of-network physician, then the first visit will be covered. Any additional visits must be authorized by the CRO. Unauthorized visits to an out-of-network physician will be paid at 50% of the amount which would have been paid to an in-network provider. These payments will be made to you, not the provider. You are responsible for paying the provider. Behavioral health services rendered by out-of-network, non-physician providers, (psychologists, social workers, etc.) are not covered under the Program.*

[9] *Certain services, including but not limited to Applied Behavioral Analysis (ABA), will be paid at 100% of the allowed amount when provided by in-network providers, and paid at 90% of the allowed amount for services provided by out-of-network providers. (See App. B, III. E. 2. b. (2)(c)).*

GM Temporary Employee Health Care Plan and Cost-Sharing At-A-Glance (for Part-Time Temporary Employees)

The chart below shows what **Part-Time Temporary employees** pay and what the Program pays.

	Traditional Care Network PPO
In-Network Deductible	$300 single / $600 family
Out-of-Network Deductible	$1,200 single / $2,100 family
In-Network Care[4]	Many services covered at 90%, you pay 10%
Out-of-Network Care[5]	Many services covered at 65%, you pay 35%
In-Network Annual Out-of-Pocket Maximum	$1,000 single / $2,000 family
Out-of-Network Annual Out-of-Pocket Maximum	Not applicable (no maximum out-of-pocket maximum)
In-Network Office Visits[6]	You pay 100% coinsurance (in-network only; out-of-network not covered)
Chiropractic Visits[6]	$25 copay per visit after deductible; limited to a combined maximum of 24 manipulation visits per calendar year
Emergency Room Visits	Subject to deductible, coinsurance and out-of-pocket maximum
Telehealth Visits[6]	You pay 100% coinsurance
Urgent Care Visits	Subject to deductible, coinsurance and out-of-pocket maximum
Prescription Drugs[6] *(34-day supply at network retail pharmacies)*	$7.50 generic $15 brand name
Prescription Drugs[6] *90-day supply*	*Select participating retail pharmacies or through Caremark Mail-Order Service* $7.50 generic $15 brand name
Preventive Services and Drugs	Annual baby/child/adult routine exam covered at 100% when receive in-network. Certain prescription and OTC meds (aspirin, fluoride prep, smoking deterrents, folic acid preparations, prescription contraceptives) require a prescription and must be dispensed by a participating pharmacy covered at 100%.
Inpatient Behavioral Health Services and Substance Use Disorder Treatment	**In-Network and Out-of-Network:** Covered 100% up to 365 days, renewable after 60 days of non-confinement. Services subject to Plan cost-sharing provisions (deductibles and coinsurance).

	Traditional Care Network PPO
Outpatient Behavioral Health Services and Substance Use Disorder Treatment ***received in both a clinical and virtual setting***	**In-Network Behavioral Health:** **Visits** **You Pay*** 1-20 $0 21-35 25% *(up to a maximum of $25)* 36+ 100% coinsurance **In-Network Substance Use Disorder:** **Visits** **You Pay*** 1-35 $0 36+ 100% coinsurance[5] **Out-of-Network Behavioral Health:** Reimbursed at 50% for treatment received from an M.D. or D.O. **Out-of-Network Substance Use Disorder:** No coverage, except in the case of an emergency, subject to certain conditions, in which case treatment is covered in full (see App. B, III. E. 2. b. (2)(b) of the Supplemental Agreement, Exhibit C). **Certain services, including but not limited to Applied Behavioral Analysis (ABA), will be paid at 90% of the* ***allowed*** *amount after deductible when provided by in-network providers, and paid at 65% of* ***the allowed*** *amount after deductible for services provided by out-of-network providers. (See App. F, Sect. 5. 2. c).*

Traditional Care Network (TCN) Option

Financing of Coverage

Under the TCN option, GM provides financing of the Plan, and partners with a selected Carrier to provide administrative services and claims processing.

Selecting A Health Care Provider

If you enroll in the TCN option, your benefits are provided through a Preferred Provider Organization, which is designed to limit your out-of-pocket costs when you use PPO providers. These providers are called network providers. You will receive the highest level of coverage when you receive services from these providers.

Although the TCN provider network through the Carrier is extensive, you have the flexibility of choosing providers other than network providers. However, before you select a health care provider, you should determine the provider's TCN participation status. The level of a provider's participation impacts the costs for which you will be responsible.

[4] *Covered services received in-network are paid at 100% of the amount the Plan allows for payment for the covered service. For the Traditional Care Network, if necessary, predetermination approvals for certain services are not obtained, services are payable at 80% of allowed charges after the first $100 of expense, up to a maximum out-of-pocket charge of $750 individual, $1,500 family.*

[5] *Covered services received from out-of-network providers are paid at 90% of the amount the Plan allows for payment of the covered service. Charges above the amount allowed by the Plan may be the responsibility of the enrollee.*

[6] *Not applied to out-of-pocket maximum accumulators.*

There are three levels of TCN participation through the Carrier (Blue Cross Blue Shield):

- PPO Network Providers
- Non-PPO Network Providers, but BCBS Participating Providers
- Nonparticipating BCBS Providers

You do not have to notify the Carrier when you select or change providers.

TCN (PPO) Network Providers: To receive the highest coverage level, you should use providers within the TCN (PPO) network. Network providers have signed agreements with the Carrier to accept the Plan's approved amount for covered services as payment in full. You will only pay for the Plan's in-network copayments, deductibles and/or coinsurances required by your coverage.

Ask your provider if they participate with your Carrier's PPO network. If you need help locating a network provider, call the Carrier's customer service number on the back of your GM health care ID card or visit the Carrier's website. The telephone number and website address are listed in the *Plan Administration* > *Who To Contact* section of this book.

When you receive services from network providers, you do not have to submit claim forms. Network providers submit claims to the Carrier for you and the providers are paid directly by the Carrier.

Non-PPO Network Providers, but Carrier Participating Providers: Although many providers are a part of the Carrier's PPO network, you have the freedom to visit an out-of-network provider and still receive coverage for covered services. Providers who are not part of the Carrier's PPO network are called out-of-network providers.

When using an out-of-network provider, try to use a Carrier approved provider. Out-of-network, but approved providers have been credentialed by the Carrier and have signed agreements to accept the Carrier's approved amount as payment in full for covered services. However, because these providers are not a part of the Carrier PPO network, you may pay a higher (out-of-network) deductible and/or coinsurance for your care. Additionally, in some cases, the services you receive from an out-of-network provider may not be covered.

When you receive services from out-of-network, but participating providers, you do not have to submit claim forms. These providers submit claims to the Carrier for you and the providers are paid directly by Carrier.

Nonparticipating Providers: Nonparticipating providers do not have signed agreements with the Carrier. This means they may or may not choose to accept the approved amount as payment in full. If your provider does not participate with the Carrier, ask if they will accept the approved amount as payment in full for the services you need. This is called participating on a "per claim" basis and means that the providers will accept the approved amount as payment in full for the specific services on the claim.

You may pay a higher (out-of-network) deductible and/or coinsurance for your care. Additionally, if a nonparticipating provider will not accept the approved amount as payment in full for covered services, you will be responsible for the difference between the approved amount and the provider's charges.

You are usually required to pay nonparticipating providers directly and then submit a claim to the Carrier for reimbursement. As a reminder, the amount the Plan reimburses you may be less than the amount your provider charged. The responsibility for paying this difference is between you and the provider.

Emergency and Referral Services: You are not required to pay a higher deductible and/or coinsurance when you receive services outside the TCN (PPO) network in certain situations. These situations include:

- If you receive treatment from an out-of-network provider for a medical emergency. **The treatment received must be for a true emergency as determined by the Carrier, pursuant to the terms of the Plan.**
- There may be a circumstance when your provider will refer you to another provider, such as a specialist. If you are referred to an out-of-network provider, you must have a Carrier PPO Referral Form completed and signed by your network physician and pre-approval from the Carrier to have the claim paid at the same level as in-network services for **each visit, pursuant to the terms of the Plan.**

In the above circumstances, you will not be required to pay the higher, out-of-network deductible and/or coinsurance.

Payment Terms

If you are enrolled in the TCN, the following payment terms, defined above in the *Common Terms*, are important for you to understand:

- *Copayment or Copay*
- *Annual Deductible*
- *Coinsurance*
- *Annual Out-of-Pocket Maximum*
- *Approved Amount*

Prior Authorization

The TCN option requires precertification (also sometimes referred to as prior authorization or predetermination *(as defined in the CBA)*) and review procedures to help you and your covered family members avoid unnecessary or prolonged hospitalization. Specifically, the appropriateness of the setting is reviewed as well as the proposed length of stay. If your hospital or physician fails to follow the prior authorization process, the coverage may be reduced. You will not be responsible for the amount of the reduction, unless you have agreed with your doctor or hospital to accept such responsibility. **If prior authorization is not granted, but you nevertheless elect to have the services performed, such services will only be payable at 80% of the approved amount after the first $100 of charges for such services. The reimbursement to providers will be reduced to reflect any waiver or forgiveness by a provider of the $100 or remaining 20%.** This benefit adjustment is limited to $750 per calendar year for an individual and $1,500 per calendar year for a family.

You should inform your physician or hospital that prior authorization can be obtained by calling the toll-free telephone number printed on your GM health care ID card.

Prior authorization is not required in cases of a medical emergency or maternity hospital admissions. **However, emergency hospital admissions must be reported by your physician or hospital within 24 hours after the admission** by calling the toll-free telephone number printed on your GM health care ID card.

Health Maintenance Organization (HMO) Options

Generally, HMOs are offered based on your residential address of record with the Company. To obtain information regarding the HMOs available to you, please contact the *GM Benefits & Services Center*. Additional literature can be obtained by contacting an HMO offered by GM in your area and requesting the membership handbook that describes its benefits and the provider directory which lists the doctors, hospitals, laboratories and pharmacies that participate in that HMO.

Health Maintenance Organizations (HMOs) are health care delivery systems or organizations which emphasize preventive health care and early treatment, as well as provide medically necessary care for illness and injury. The scope and level of benefits and coverages provided by an HMO may differ from the TCN option.

Financing of Coverage

GM pays the HMO premiums and each HMO handles administration and claims processing.

Selecting a Health Care Provider

Primary Care Physicians: If you enroll in HMO coverage, you and your enrolled dependents must select a primary care physician (PCP). Your PCP can be an internist, general practitioner, family practitioner or pediatrician. To receive coverage under an HMO Plan, your PCP must coordinate all of your health care, including:

- Making specialist referrals to a preferred care provider in the HMO network
- Coordinating hospital stays
- Handling paperwork and claims for you

Exceptions where you do not require referral assistance from your PCP include emergency services and an annual routine gynecological examination with direct access to network OB/GYNs. You must receive a referral from your PCP, however, for follow-up visits or treatment.

If you need help locating a network provider, call the HMO's member service center or visit their website. The telephone number and website address are listed in the *Plan Administration* > *Who To Contact* section.

Emergency Services: When you follow the proper procedures, emergency care is generally covered by the HMO after the applicable copayment. If you use an emergency facility that is not participating with the HMO's network, you may be required to pay for the emergency treatment at the time of service and request reimbursement from the HMO later. In this case, it is very important that you obtain a detailed bill from the provider to submit to your HMO. You or a family member should also call the HMO or your PCP as soon as possible, but no later than two business days after receiving emergency treatment.

A brief summary of the coverages provided by each HMO offered under the Program is located at **gmbenefits.com**.

Certificate of Insurance

If you are enrolled in (or considering enrolling in) an HMO, the HMO will provide you with a certificate describing the scope and level of benefits that are available through that HMO. The applicable information in the certificate you receive from the HMO is incorporated in this SPD by reference.

Generally, the certificate will describe:

- Additional information regarding any cost-sharing provisions for which the Participant will be responsible
- Any annual or lifetime caps or other limits on benefits under the Plan
- The extent to which preventive services are covered under the Plan
- How new and existing drugs are covered under the Plan
- Whether and under what circumstances, coverage is provided for medical tests, devices and procedures
- Provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services, and any conditions or limits for selection of primary care providers or providers of specialty medical care
- Any conditions or limits applicable to obtaining emergency medical care
- And any provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service under the Plan.

The HMO's Certificate of Insurance will also provide information on procedures for filing claims, providing notifications of benefit determinations and reviewing denied claims. Some of these features may vary from one HMO to another. HMO benefits must be consistent with the level of benefits negotiated by the Company and/or with the union, as applicable.

HMOs have monitoring systems to assess quality of care, necessity of treatment and appropriateness of inpatient hospital stays. The coverage varies among individual HMOs, but all HMOs include certain preventive and routine care services such as physical exams, office visits and immunizations. Generally, such care is provided at lower or no cost to you.

HMOs also provide coverage for prescription drugs, behavioral health and substance use disorder treatment and other services. Since coverage of services may vary from the TCN option and between HMOs themselves, it is important to review HMO materials carefully to become familiar with the scope and level of benefits and coverages that are available through a particular HMO.

Your Medical and Hospitalization Benefits – Covered Services

This section generally describes the types of medical, surgical and hospitalization services covered.

Office Visit Coverage

Office visits with in-network providers are covered subject to the cost-sharing provisions outlined in the section titled *Medical Plan Options*. Office visits with an out-of-network provider are not covered, unless an enrollee lives outside of the defined service area and the service is pre-approved by the Carrier.

Preventive Services

The services listed below are covered as preventive service. If rendered by an in-network provider, they are exempt from deductibles, copayments, or coinsurance that might otherwise apply. If services are provided by an out-of-network provider, they are subject to applicable cost-sharing provisions.

In instances where the coverage within a time period is limited, the first such service rendered in the time period will be considered preventive. Other covered services including diagnostic services, services provided outside any specified age-related windows, additional services within the specified periods, or services provided outside the specified periods will be subject to any applicable cost-sharing features.

- Mammograms: One routine mammography screening per calendar year, starting at age 40
    - The maximum benefit payable for digital mammography is the Carrier approved amount for the alternative film mammography
- Pap smear: Laboratory and pathological service for one (1) test per calendar year
- BRCA Testing, one (1) per lifetime
- Women's Contraceptive Methods: IUD, Diaphragm, Cervical Cap (other methods may be covered, limitations may apply)
- Proctoscopic examinations without biopsy: One (1) screening exam every three (3) calendar years, after age 40 is attained
- Well Care: Up to eight (8) visits for babies under one (1) year of age; up to six (6) well visits from age 13 months through age 23 months; up to six (6) well visits from age 24 months through age 35 months, two (2) well visits from age 36 months through age 47 months; and one (1) health maintenance exam per year from 48 months through adulthood.
- Hearing loss screening for newborn through age 21, once per calendar year
- Vision screening for newborn through age 21, once per calendar year
- Cholesterol screening for children age 24 months to 21 years; for men over age 35; for men age 20-35 and women over age 20 if at an increased risk for coronary heart disease
- One routine physical examination per calendar year for enrollees age 18 and older
- One routine gynecological examination per calendar year for female enrollees
- Additional screening tests for newborns, children, adults and pregnant women
- Immunizations and vaccinations, coverage is provided for administration of certain immunizations and vaccinations
- Prostate Specific Antigen (PSA): One (1) screening PSA test per year for enrollees ages forty (40) and older
- Fecal Immunochemical Test: One (1) test per year, beginning at age 50
- Flexible Sigmoidoscopy, Barium Enema and Colonoscopy: Coverage for barium enema is provided for one (1) every 5 years when no colonoscopy within 10 years or no sigmoidoscopy within 5 years. Coverage is provided for one (1) flexible sigmoidoscopy **or** one (1) fecal occult blood test or one (1) colonoscopy every year

- One (1) ColoGuard Oncology Screening covered every three (3) years
- Infectious Disease Screenings
    - Chlamydia: one (1) per year for men and women through age 21 (women over age 21 if risks factors present)
    - Gonorrhea: one (1) per year for men and women through age 21 (women over age 21 if risk factors present)
    - Syphilis: one (1) per year for men and women at any age
    - HIV: one (1) per year for men and women of any age
    - Hepatitis B: one (1) per year for men and women of any age with risk factors
    - High-risk Human Papillomavirus (HPV): DNA testing for women of any age, one (1) per year
- Consultations for issues like breastfeeding, obesity, healthy diet, alcohol misuse, tobacco use, skin cancer behavioral consultation, contraceptive use and domestic violence (conditions and limitations apply).

Medical and Surgical Coverage

Under Medical and Surgical provisions, coverage is provided for medically necessary:

- Surgery and anesthesia, including pre- and post-operative care
- Obstetrical delivery, including pre- and post-natal care provided by a physician, or by a nurse mid-wife when received in a hospital or birthing center affiliated with a hospital
- In-hospital consultation
- In-hospital medical care by the doctor in charge of the case
- Doctor's medical visits, at the rate of two per week, for up to 730 days in an approved skilled nursing facility for general conditions
- Audiometric tests and hearing evaluation services when used to diagnose any condition, disease or injury of the ear
- Radiation therapy and chemotherapy for certain types of malignant conditions
- Certain human organ transplants (some of which may be subject to coverage limits)
- Laser surgery which replaces a cutting procedure
- Necessary and appropriate diagnostic x-ray, laboratory and pathology services
- Outpatient treatment of accidental injuries and certain medical emergencies and observation care (following a medical emergency)
- Immunizations for the treatment for rabies exposure, Respiratory Syncytial Virus (RSV) and Herpes Zoster (Shingles)
- Voluntary sterilization (but not reversals)
- Medical services required for contraceptives

- Gender affirming services when ordered by a licensed physician with prior authorization from the medical plan Carrier for services including, but not limited to:
  - Psychotherapy
  - Puberty suppression in adolescents
  - Hormone therapy (for masculinization/feminization)
  - Electrolysis (specific to genital reconstruction)
  - Gender affirming surgery/ies, including genitalia reconstruction *(as defined in the CBA)*
- In the case of an enrollee who undergoes a mastectomy and elects breast reconstruction in connection with the mastectomy, coverage includes:
  - Reconstruction of the breast on which the mastectomy has been performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient
- The ***first*** set of prescription lenses (eyeglasses or contact lenses) following a cataract operation for any disease of the eye or to replace the organic lens missing because of congenital absence (after the first set, eyeglasses or contact lenses are covered under the Program's vision coverage).

Hospital Coverage

In-Network

Inpatient hospital coverage is provided for up to 365 days of covered care in a semiprivate room in a network hospital for general conditions, including maternity care. Precertification (*pre-determination, as defined in the CBA)* is required for non-emergency, non-maternity hospitalizations to be eligible for coverage. Precertification must be obtained within 24 hours for emergency admissions. If precertification is not obtained, payment (of benefits) is reduced by 20% after the $100 deductible.

Plans and insurers may not, under federal law, require that a provider obtain prior authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

Covered inpatient hospital services include, but are not limited to:

- Semiprivate room, general nursing services, meals and special diets. Charges for a private room are covered at the Hospital's standard rate for a semiprivate room, unless a private room is medically necessary
- Medical/surgical supplies, drugs and medicines
- Use of operating rooms, other surgical treatment rooms, delivery rooms and recovery rooms
- Anesthesia services
- Blood products and their administration (blood or component preservation and storage for future use are not covered)
- X-rays, EKGs, CT scans, ultrasounds, magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA)
- Laboratory and pathology services

Covered outpatient hospital services (restrictions may apply) include, but are not limited to:

- Medical emergencies
- Observation care immediately following outpatient surgery or diagnostic testing
- Medical/surgical supplies, drugs, biological and solutions
- Physical therapy, speech therapy and functional occupational therapy (see *Physical, Occupational and Speech Therapy Coverage* section)
- Chemotherapy treatments
- Pulmonary functions evaluation
- Hyperbaric oxygenation
- Hemodialysis
- Laboratory test
- Use of operating rooms, other surgical treatment rooms, delivery rooms and recovery rooms
- Anesthesia services
- Blood products and their administration (blood or component preservation and storage for future use are not covered)
- X-rays, EKGs, CT scans, ultrasounds, magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA)

Out-of-Network (Excluding Psychiatric Hospitals)

Emergency room services received at an out-of-network hospital are covered in full, with the applicable cost-sharing (see *Medical Plan Options*). If you are admitted to an out-of-network hospital for a medical emergency, including treatment for an accidental injury, the first five (5) days of hospitalization are eligible for full coverage.

Coverage for **inpatient care** received at an out-of-network hospital is limited to $500 per day for room and board and $50 per day for ancillary charges.

If you receive **outpatient services** at an out-of-network hospital, coverage is limited to $50 for each outpatient visit.

What is Not Covered

- Services that are not medically necessary
- Services that are domiciliary, custodial, or convalescent in nature
- Facility charges for care received in an urgent care center (charges for physician services are generally covered)
- Inpatient or outpatient services related to non-covered plastic, cosmetic and reconstructive surgery
- Services that are considered experimental/investigational
- Emergency room visits that do not qualify as a medical emergency
- Hospital services consisting principally of dental treatment or extractions

Physical, Occupational and Speech Therapy Coverage

Up to 60 combined visits (per qualifying condition) per calendar year are covered for outpatient physical, functional occupational, and/or speech therapy provided by an in-network hospital, Freestanding Outpatient Therapy Facility, Home Health Care Agency, *Skilled Nursing Facility*, physician or licensed therapist under the following circumstances:

- Coverage for physical therapy is available only if it is provided with the expectation that the condition will improve in a reasonable and generally predictable period of time, or improvement is noted on a periodic basis in the patient's record.
- Speech therapy is covered on an outpatient basis or in an office setting when related to the treatment of an organic medical condition or to the immediate post-operative, or convalescent state of the enrollee's illness. Such services are subject to the sixty (60) visit limitation. Speech therapy for congenital and severe developmental speech disorders is a covered service when not available through other public agencies, up to sixty (60) visits annually.

If you are enrolled in the Traditional Care Network (TCN), your benefits for physical, occupational, and speech therapy services are administered by Blue Cross Blue Shield of Michigan. You can find an in-network provider by logging into your member portal or calling BCBSM customer service on the back of your GM health care ID card.

Fertility Services

Diagnostic testing to identify causes of infertility, and procedures to correct underlying fertility-related medical conditions are covered benefits.

You and your spouse (if enrolled) each have access to a maximum of $5,000 annually towards expenses associated with services to treat infertility. Covered fertility services include, but are not limited to:

- Artificial insemination (IUI)
- Assisted reproductive technologies (ART)
- Prescription drugs as part of fertility treatments including, but not limited to, medications related to IVF, IUI, or ovarian stimulation, and oocyte (egg) induction

Fertility services are covered when furnished and billed by an eligible provider and approved by the Carrier. A diagnosis of infertility is required to receive covered fertility services.

Skilled Nursing Facility Coverage

Medically necessary admissions to an in-network skilled nursing facility are covered for up to 730 days (reduced by 2 for each inpatient hospital day used during a benefit period of care), including:

- Semiprivate room, general nursing service, meals and special diets
- Use of special treatment rooms
- Routine laboratory examinations
- Physical, speech, or functional occupational therapy when medically necessary (see App. A, III. C. of the Supplemental Agreement, Exhibit C)
- Oxygen and other gas therapy

- Drugs, biologicals and solutions used during the facility stay
- Gauze, cotton, fabrics, solutions, plaster, splints and other materials used in dressings and casts
- *Durable medical equipment*

WHAT IS NOT COVERED

- Conditions that are not medically necessary and do not require skilled nursing services
- Admissions that are principally custodial or domiciliary in nature or for treatment of tuberculosis
- If you have reached your maximum level of recovery possible for your particular condition and no longer require treatment other than routine supportive care

Home Health Care

Coverage, up to the approved amount, for medically necessary services is provided by an approved home health care program for general nursing services, physical therapy, speech therapy, social service guidance, dietary guidance, functional occupational therapy and part-time health aide service.

Coverage for home health care services is limited to up to three (3) visits for each remaining unused day of inpatient hospitalization during a benefit period. The maximum number of home health care visits eligible for coverage per benefit period is 1,095 (which is 365 hospital care days times three). For specific details regarding coverage for home health care, please refer to Appendix A, III. C of the Supplemental Agreement (Exhibit C).

Pre-Hospice and Hospice Coverage

You are eligible for pre-hospice care of up to twenty-eight visits (28) when certified by a physician and have been diagnosed with a terminal illness. Pre-hospice services must consist of evaluation, consultation and education, and support services. Coverage is available for up to 365 days of hospice services if you are terminally ill when provided through an **approved** hospice program. The benefit period can be extended beyond 365 days if authorization is obtained from the Carrier's case management program.

Ambulance Coverage

Ambulance services for medically necessary ground, air, or boat transportation to the closest available facility are covered for:

- One-way or round trip for transfers between hospitals, because the originating hospital lacks necessary treatment facilities, equipment, or staff
- One-way or round-trip transfer for a hospital inpatient who must be taken to a non-hospital facility for a covered CAT scan, MRI or PET examination (provided the facility meets the Program standards for providing such services), when the services are not available in the hospital to which the patient is admitted or in a closer local hospital

- Emergency transportation for:
    - transporting a patient one-way from home or scene of incident in cases of medical emergency or accidental injury to the nearest available facility qualified to treat the patient; and
    - round-trip transfer of a homebound patient from the home to the nearest available facility qualified to treat the patient in the case of a medical emergency or accidental injury, or for treatment at a facility when other means of transportation cannot be used without endangering the patient's life

Air and boat ambulance services are covered only when deemed to be medically necessary, and ground ambulance or other means of transport could not be used without endangering the patient's health. You will be protected from balance billing for non-participating air or boat ambulance rides when medically necessary.

Durable Medical Equipment (DME) and Prosthetic and Orthotic Appliance (P&O) Coverage

When a doctor prescribes medical equipment or appliances, the items may be covered by your medical plan, whether used in a hospital or skilled nursing facility or after discharge. Coverage is provided when your physician prescribes such equipment, and the Carrier approves it. The Carrier administrating benefits for coverage of durable medical equipment and prosthetic and orthotic appliances is Blue Cross Blue Shield of Michigan.

You, your physician, or your provider may contact the Carrier for prior authorization, claims processing, assistance in locating participating providers, and for any other questions or concerns.

DURABLE MEDICAL EQUIPMENT (DME) COVERAGE INCLUDES:

- Equipment that meets Program standards, which generally include being approved for reimbursement under Medicare Part B, and being appropriate for use in the home
- Equipment used in a hospital or skilled nursing facility and rented or purchased from such hospital or facility
- Repairs necessary to restore the equipment to a serviceable condition when such equipment is purchased (this does not include routine maintenance)
- Neuromuscular stimulators
- Positioning transportation chairs as alternatives to traditional wheelchairs for children under 14 years of age, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders, or congenital abnormalities
- External electromagnetic bone growth stimulators, in certain approved cases
- Phototherapy (bilirubin) light for patients under the age of one (1)
- Continuous passive motion device for use on elbow and shoulder following surgical treatment
- Pressure gradient supports for certain patients
- Pronged and standard canes (when purchased)
- Continual Glucose Monitors, and insulin pumps, including the OmniPod, are covered for diabetics who meet Control Plan standards

PROSTHETIC AND ORTHOTIC (P&O) APPLIANCES COVERAGE INCLUDES:

- P&O appliances that are furnished by an accredited facility and meet Program standards, which generally include being approved for reimbursement under Medicare Part B and the replacement, repair, fitting and adjustments of the appliance
- One (1) pair of medically necessary orthopedic shoes, inserts, arch supports and shoe modifications will be covered once per calendar year.
- Appliances or devices that are surgically implanted permanently within the body (except for experimental or research appliances or devices) or those which are used externally while in the hospital as part of regular hospital equipment or when prescribed by a physician for use outside the hospital
- Wigs and appropriate related supplies for hair loss from the side effects of chemotherapy, radiation, or other treatments for cancer:
    - for the first purchase of a wig and supplies, the maximum benefit will be $200; and
    - thereafter, a maximum annual benefit of $125 will be provided for such purchases.

Hearing Aid Coverage

For hearing aid benefits to be covered you first must have a medical examination of the ear by a physician prior to receiving your initial hearing aid. Subsequent medical examinations are not required in connection with a replacement hearing aid. However, enrollees under the age of 18 must continue to have a medical examination of the ear each time a hearing aid is dispensed. If it is determined that your hearing problem may be corrected by use of a hearing aid, benefits can be provided.

Payment will be made for the Carrier approved amount for the following services and product, up to maximum of $2,200, once every 3 years:

- Audiometric examination
- Hearing aid evaluation test
- Hearing aid and covered ear molds

Hearing aid benefits are administered by AudioNet America. To find an in-network provider, you should contact *AudioNet America*.

HMOs also provide coverage for hearing aids. Since coverage of services may vary from the TCN option and between HMOs themselves, it is important to review HMO materials carefully to become familiar with the scope and level of benefits and coverages that are available through a particular HMO.

How Prescription Drug Coverage Works

Important Terms

The following terms are used to describe certain elements of Prescription Drug Coverage:

- A **Brand Name Drug** is a drug which is covered by a patent and for which an equivalent version cannot be manufactured, marketed, or a drug which is no longer covered by a patent and for which chemically equivalent versions can be manufactured and marketed.
- A **Generic Drug** is a drug that is chemically equivalent to a brand name drug.
- An **Erectile Dysfunction (ED) Drug** is a drug prescribed primarily for the treatment of erectile dysfunction.

Cost-Sharing Provisions

The copays you are responsible for when filling a prescription at an in-network retail pharmacy and through mail-order services are outlined in the *Medical Plan Options* section above.

Preventive Prescription Drugs Not Subject to Cost-Sharing

Certain preventive medications are covered at 100% and not subject to copay if you have a written prescription order from a licensed provider and the medication is dispensed at a network retail pharmacy or through the mail-order pharmacy, subject to the Carrier's standards.

A list of the preventive medications can be found at *CVS Caremark*.

What's Covered

If you are enrolled in TCN option, prescription drug coverage provides payment of the prescription charge, less the applicable copayment, for each separate prescription order or refill for the purchase of:

- Covered drugs (including contraceptive medications) and diaphragms which require a prescription by a licensed physician
- Injectable insulin, self-injectable anti-neoplastic agent, or other self-injected drug meeting Program standards and disposable syringes and needles when prescribed and dispensed with them
- Covered vitamins are limited to prenatal vitamins for females under the age of 49, Vitamin D derivatives prescribed to treat renal disease, Vitamin K prescribed for bleeding conditions, long-acting Niacin for treating heart conditions and potassium chloride.

What's Not Covered

The following medications are not covered under the Program:

- Any research or experimental agent including Federal Food and Drug Administration approved drugs which may be prescribed for research or experimental treatment
- Any medication prescribed for cosmetic purpose
- Any charge for devices (other than diaphragms) or appliances (e.g., orthotics)

- Any charge for a vaccine administered for prevention of infectious diseases
- Antineoplastic (e.g., chemotherapy) agents except those that can be self-administered through subcutaneous or intramuscular injection or oral dosage form and are not covered under another subsection of the Plan (Appendix A or Appendix B of the Exhibit C-1 of the CBA)
- Any charge for the administration of covered drugs
- Any charge for a covered drug in excess of the amount specified by the physician or a refill dispensed more than one year from the physician's order
- Any charge for more than a thirty-four (34) day supply at retail
- Any charge for medications furnished on an inpatient or outpatient basis covered under another subsection of the Plan (Appendix A or Appendix B of the Exhibit C of the CBA)
- Dapoxetine
- Non-sedating antihistamines
- Any charge for compounded medications unless a request for medical exception is evaluated and authorized by the carrier

Pharmacy Network

Locating a Network Pharmacy

There are thousands of network pharmacies nationwide, including chain pharmacies, independent pharmacies and CVS Pharmacy locations including those inside Target stores. You may contact CVS Caremark at the number on the back of your GM health care ID card or visit **caremark.com** to locate a network pharmacy anywhere in the country. When you are traveling out of your home area, or if you have dependents living away from home, the customer service representative on the toll-free line will assist you in locating the nearest network pharmacy.

Using an Out-of-Network Pharmacy

If you have a prescription filled at an out-of-network pharmacy, you will pay the full cost of the prescription. If you submit a claim form to CVS Caremark afterwards, you will be reimbursed for 75% of the Carrier approved amount less the applicable copayment. You are responsible for the 25% difference. Claim forms may be obtained online at **caremark.com** or by calling CVS Caremark at the number on the back of your GM health care ID card.

In the case of an emergency, out-of-network claims for covered prescriptions will be covered at 100% of the Carrier approved amount less the applicable copayment when obtained from providers located outside the area, or from in-area out-of-network providers.

Maximum Supply Per Prescription Filled

When you fill a prescription at:

- Any network retail pharmacy, a 34-day supply is the maximum you can receive for one copayment.
- Select participating retail pharmacies or through the CVS Mail-Order Service, you may receive a 90-day supply for one copayment.

Certain covered drugs come in pre-packaged quantities exceeding these day limits. If these pre-packaged drugs cannot be repackaged, the copayment will be pro-rated to account for the additional supply.

If disposable syringes and needles are dispensed at the same time as either injectable insulin self-injectable anti-neoplastic agent, or other self-injected drug meeting Program standards, they will continue to be covered at retail or mail order and will not require a separate copayment.

90-Day Prescription Drug Supply Options

If you are taking any medications on a regular basis, you may be able to save money by purchasing your prescription in a 90-day supply. You have two options for filling a 90-day supply prescription.

- Select Participating Retail Pharmacies: You may obtain a 90-day supply prescription at select participating retail pharmacies by bringing your prescription to a select participating retail pharmacy location or having your doctor submit your prescription to the select participating pharmacy of your choice.
- Mail-Order Pharmacy: Mail-order is a convenient way to have 90-day supplies of your long-term medications delivered to your home, postage-paid. Your prescription will be delivered within 10 days from the date that CVS Caremark receives your prescription order. Filling a prescription through the mail-order service can save you both time and money. You don't have to make trips to the pharmacy every 34 days and a 90-day supply typically costs less than three 34-day prescription fills.

How to Use the Mail-Order Service

Once your doctor has determined that you require medication on an ongoing basis, they may prescribe up to a 90-day supply, plus refills, for dispensing through mail order. If you are now taking medication on a long-term basis, and are not currently using the mail-order option, ask your doctor for a new prescription written for a 90-day supply. A year's worth of medication would include three refills covering up to 90 days each.

To begin filling your prescription through Mail-Order Service, you can contact CVS Caremark through one of the following:

(1) **Phone:** Call CVS Customer Care toll-free at 1-844-379-1671.

(2) **Online:** Visit **caremark.com/mailservice** and sign in. Follow the guided steps to request a prescription.

(3) **Fax:** Your doctor can return a mail service order form via fax at 1-800-378-0323.

(4) **Mail:** Fill out and return a mail service order form. You can download one at **caremark.com**, or you can obtain one from CVS Customer Care toll-free at 1-844-379-1671.

When you order your prescriptions by mail, you will not have to submit claim forms or wait for reimbursement. Your medication is delivered to your home, postage-paid, within 10 days from the date that CVS Caremark receives your prescription order.

Prescription Drug Management Programs

Your prescription drug benefits include some programs that provide both safe and cost-effective measures toward your prescribed treatments. These programs are described more fully below.

Mandatory Generic Drug Policy

Generic drugs are effective yet significantly less expensive than brand name drugs. Whether you fill a prescription at a retail or mail-order pharmacy, if a brand-name drug is dispensed instead of its generic version, you must pay the applicable copayment plus the difference in price between the brand-name and generic drug. Your doctor or pharmacist can advise you about whether a generic drug is available.

- At a retail pharmacy, if your doctor has specified a brand-name drug (by indicating "Dispense as Written" or DAW), your pharmacist may contact your doctor to authorize the generic version. If your doctor agrees, you will receive the generic drug for the generic copayment. If the doctor disagrees or cannot be contacted, you will be given the brand-name drug and charged the brand copayment plus the difference in cost between the brand and generic, up to a maximum of $10, for the first fill. After that, you will pay the generic copayment *plus* the **full** difference in Program cost between the brand-name and the generic drugs.
- Either you or your doctor, may initiate a review with CVS Caremark of the medical necessity for dispensing a brand name drug rather than a generic. If it is found that the dispensing of the brand name drug was medically necessary, you will be refunded the appropriate amount once a paper claim is submitted and CVS Caremark will allow for dispensing of the brand-name drug thereafter. If the review is denied, you and your doctor will be informed and provided information on the appeals process.

There are a small number of brand-name drugs that have generic equivalents, but for which small variation in the dose could result in changes in drug safety. These drugs are not subject to the generic dispensing provision. When these brand-name drugs are dispensed, only the brand copayment will apply.

If your doctor has not indicated "Dispense as Written" or DAW, your prescription automatically will be filled with a generic drug. If you still want the brand-name drug, you will continue to pay the generic copayment plus the full difference in Program cost between the brand-name and generic drug.

90-Day Supply for Maintenance Medications

At retail, prescription drug coverage is limited to a maximum 34-day supply of covered drugs. However, you may require medications on a long-term basis (3 months or more) to treat chronic conditions such as high blood pressure or high cholesterol. There is a select list of such medications which should be purchased through mail order or select participating retail pharmacies. You will be advised by CVS Caremark if you are taking a medication on this list. If you decide to continue to purchase a medication on this list at retail, after the first three fills, you will have to pay a 100% copayment.

To avoid paying a 100% copayment at retail, you will need a 90-day prescription that can be filled at a select participating retail pharmacy or through the CVS Mail-Order Service. Filling a prescription at a select participating retail pharmacy or through the CVS Mail-Order Service allows you to obtain an up to 90-day supply for one copayment.

Specialty Pharmacy

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. CVS Specialty Pharmacy is composed of therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs.

A separate pharmacy network is in place for specialty drugs. Before filling your specialty drug prescription, please contact *CVS Specialty Pharmacy* to find a network specialty pharmacy. Not all retail pharmacies can fill a specialty drug prescription.

Prior Authorization

Criteria for coverage approval is predefined for certain drug classes. If your medication falls within this list, it is necessary to have your physician contact CVS Prior Authorization to provide information that ensures you are meeting the clinical recommended criteria for the prescription. After receiving this information, CVS determines whether or not coverage under the plan is approved. Contact *CVS Caremark* to learn what drug classes are subject to prior authorization.

Step Therapy

When many different drugs are available for treating a medical condition, it is often useful to follow a step-wise process for finding the best treatment for an individual. This process, known as step therapy, provides an effective approach to reducing the cost of drugs for you and the health plan. In step therapy, specific high-cost, second-line, and/or non-preferred drugs are covered by the Plan only after first-line, clinically appropriate, proven and/or cost-effective drugs are tried.

In partnership with both pharmacists and physicians, CVS Caremark has developed an automated Step Therapy program as a drug use management tool. This program is geared to ensure that you are receiving the best medication recommended for your condition. Here is a quick overview of how it works:

- When a prescription for a second-line (lower cost) drug is being processed at your pharmacy, the online system will scan your recent prescription records.
- If the system finds a record for a first-line alternative, the Step Therapy program will not interrupt the dispensing process.
- If the system does not find a prescription for a first-line alternative to your prescription, it will alert the pharmacist and they may contact your prescribing physician to recommend a more cost-effective first-line drug.

Contact *CVS Caremark* to learn what drug classes are subject to step therapy.

Utilization Management

To promote safety and clinically appropriate care while maintaining the costs of prescription drug coverage, the Carrier may administer additional utilization review processes such as dose and quantity edits, dose duration edits and dose optimization edits related to select drugs or drug classes.

Behavioral Health and Substance Use Disorder Treatment Coverages

If you are enrolled in the TCN option, coverage for behavioral health and substance use disorder treatment is administered by Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan has a network of qualified providers and promotes the delivery of care in appropriate settings.

Important Terms

The following terms are used to describe certain elements of the Behavioral Health and Substance Use Disorder benefit:

Network providers are behavioral health or substance use disorder providers who participate in, and make up the Carrier's network. The Plan uses the term Panel Providers.

Out-of-network providers are behavioral health or substance use disorder providers that are not part of the Carrier's network. The Plan uses the term Non-Panel Providers.

If you have any questions regarding your coverage for behavioral health/substance use disorder treatment or need services, contact *Blue Cross Blue Shield of Michigan* Remember, you must use in-network providers to receive full amount of available coverage.

How to Receive Care

Blue Cross Blue Shield of Michigan uses an integrated behavioral health and substance use disorder treatment delivery system which includes:

(1) A national Central Review Organization (CRO) designated to: (1) confirm the eligibility of the patient for coverage under the Program; (2) authorize and approve all inpatient and outpatient behavioral health treatment, certain courses of outpatient substance use disorder treatment and outpatient psychological testing; and (3) evaluate in-network providers.

(2) A network of Central Diagnostic and Referral assessment coordinators (CDRs) located in most communities, responsible for making assessments required under the Program for the development of substance use disorder continuing care treatment plans. In addition, CDR assessment coordinators make determinations regarding whether the patient's condition requires behavioral health and/or substance use disorder treatment. The CDR assessment coordinators also make referrals to in-network providers, provide short-term counseling (up to two visits) and perform aftercare planning and follow-up. In addition, CDR assessment coordinators may provide up to three short-term counseling sessions for enrollees. The CDR assessment coordinator may communicate with Work/Family program representatives about assessment and referral activities related to an enrollee, where appropriate, and when authorized by the enrollee.

(3) An extensive nationwide network of inpatient and outpatient behavioral health and substance use disorder professionals and facilities including:

- Psychiatrists
- Ph.D. psychologists
- Licensed social workers with a master's degree
- Behavioral health clinicians who are licensed in their state at the highest independent practice level for that license
- Clinical nurse specialists
- Hospitals, day/night programs, halfway houses and detoxification facilities

Cost-Sharing Provisions

The combined coverage for behavioral health and substance use disorder treatment is outlined in the *Medical Plan Options* section above.

What's Not Covered

Coverage is not available for treatment of behavioral disorders which are not amenable to improvement (except that coverage is available to determine that the disorder is not amenable to favorable modification) or for the evaluation and diagnosis of cognitive disability/impairment.

The coverage is structured in such a way that every enrollee will have easy access to care through a network of providers. **If substance use disorder services are rendered by an out-of-network provider, the services are not covered unless an out-of-network authorization is secured from the CRO prior to treatment.**

Travel Expense Reimbursement for Covered Health Care Services

Certain travel and lodging expenses primarily for, and essential to, receiving covered health care services under the Program are eligible for reimbursement if a network provider is not available within 150 miles of your primary residence and virtual care is not an option. To qualify for reimbursement:

- Travel and lodging expenses must be incurred to receive covered health care services from the nearest network provider in a location where the services are available and permitted under applicable state and local law; and
- Costs associated must be for U.S. domestic travel and lodging for you or your covered family member, and one companion to travel from your home address; and
- Travel expenses eligible for reimbursement are limited to those defined as medical expenses under Internal Revenue Code Section 213(d) and its implementing regulations and sub-regulatory guidance (see **IRS Publication 502** for details); and
- Total maximum travel and lodging benefit is not to exceed $2,000 annually per person enrolled in the Medical Plan.

Plan Exclusions and Limitations

Certain health care services and charges are excluded or limited. A description of general exclusions, and limitations applicable to each benefit provided under the Health Care Program, may be found in the appropriate Program language, or similar documents provided by GM or the Carriers.

The following are examples of additional services excluded from coverage:

- Programs and/or surgical procedures that are considered to be research, investigational or experimental in nature
- Hospital charges related to domiciliary, custodial, convalescent, nursing home or rest care
- Certain skilled nursing facility charges
- Private duty nursing; nursing care, which is privately contracted by, or on behalf of, an enrollee with a nurse, or agency, independent of the program

- Services, care, or treatment that are not medically necessary according to accepted medical standards
- Services that are not related to specific diagnosed illness or injury such as pre-marital or pre-employment examinations
- Services available through other programs
- Personal convenience items
- Charges for the completion of any claim forms; and
- Services provided by family members.

Claims

Your Social Security number, your GM employer identification number, or alternate identification number issued to you by the Carrier may be needed when you communicate with any of the Carriers. If you are an enrolled dependent, the Social Security or alternate identification number of the employee, retiree, or surviving spouse through whom you have coverage will be needed.

Hospital, Medical, Surgical and Behavioral Health/Substance Use Disorder Claims

If your Carrier is Blue Cross Blue Shield, show your GM health care ID card when you go to the hospital, outpatient treatment facility, physician, or other provider of covered services anywhere in the country. In-network providers will be paid directly by Blue Cross Blue Shield for covered services.

In any situation where a provider of a service is not paid directly by Blue Cross Blue Shield, you should submit the charges to Blue Cross Blue Shield. You may call customer service on the back of your GM health care ID card for assistance.

If you utilize an out-of-network provider, you may be required to file a claim. Instructions and forms can be obtained by calling your Carrier, see the *Who To Contact* section for telephone numbers or the customer service number on the back of your GM health care ID card.

Hearing Aid Claims

Network providers generally will have the necessary hearing aid claim forms. Benefits will be paid directly to the provider by the Carrier.

Prescription Drug Claims

When you fill prescriptions at a network pharmacy, the appropriate charges will be filed electronically by the pharmacy. If you fill a prescription at an out-of-network provider, you will be required to pay the full charge and file a claim. Claim forms may be obtained by calling *CVS Caremark*. You and/or the provider may complete all the required information on the form. You may then mail the claim to the address noted on the form. You will be reimbursed the appropriate amount after your copayment has been deducted.

DENTAL PLAN (NON-CORE COVERAGE)

Understanding Your Benefits

(Traditional) Dental Plan At-A-Glance

Service / Treatment	Preferred PPO Plan Pays	Premier Plan Pays	Non-Participating[10] Plan Pays
Class I (includes diagnostic and preventive services such as exams, routine cleanings, fluoride treatments and emergency palliative treatments)	100%	100%	100%
Class II (includes X-rays; relines and repairs to crowns, bridges and dentures; minor restorative services (e.g., fillings); periodontic services; endodontic services)	100%	90%	90%
Oral Surgery	90%	90%	90%
Major Restorative Services (e.g., crowns and implants)	90%	90%	90%
Prosthodontic Services (e.g., bridges and dentures)	70%	50%	50%
Orthodontia	60%	50%	50%
Annual Maximum Benefit per Enrollee	$2,000	$2,000	$2,000
Lifetime Orthodontia Maximum per Enrollee (up to age 19)[11]	$2,200	$2,200	$2,200

Important Reminder: **Traditional, In-Progression, and Full-Time Temporary employees** are eligible for coverage in the Dental Plan. **Part-Time Temporary employees** are not eligible for the coverage under the Dental Plan.

The Dental Plan is administered by Delta Dental Plan of Michigan (Delta Dental). Benefits are payable based on Delta Dental's established fee schedule of allowed amounts. As the Dental Plan Administrator, Delta Dental provides access to two provider networks: Delta Dental Premier and Delta Dental PPO. **You can increase your benefits, while lowering your costs, when you receive services from a dentist in the PPO network.** This means that your out-of-pocket costs will be lower, and your annual and lifetime maximum benefits will go further. The PPO network operates within Delta Dental and does not require special enrollment. Use of a PPO or Premier network dentist is voluntary, yet there will be greater savings to both you and GM if you seek treatment from a PPO dentist. If you choose to utilize a non-participating dentist, in addition to your applicable copayment, you may be responsible for the difference between the amount charged by the dentist and Delta Dental's established fee schedule of allowed amounts.

[10] *When you receive services from a non-participating dentist, the percentages in this column indicate the portion of the Carrier's non-participating dentist fee that will be paid for those services. This amount may be less than what the dentist charges or the amount the Carrier approves and you will be responsible for that difference.*

[11] *For orthodontic treatment, the lifetime maximum is $2,200 per enrollee, and is available for enrollees whose course of treatment begins before age 19. Coverage is not available for treatment begun after attainment of age 19.*

Accidental Dental Injury

Additional coverage is available for the repair of accidental dental injury to sound natural teeth due to sudden unexpected impact from outside the mouth. If applicable in a given case, the copayments referenced above will apply (depending upon the nature of the service(s), but benefit payments will not count against annual or lifetime maximums.

For this component to apply, the...

- Annual maximum benefit must be exhausted, and
- Accident must be documented, e.g., police report, and
- Services received must be a direct result of the accident and are provided within one year of the accident.

How the Plan Works

The following information is applicable when you receive dental services from a *Delta Dental Premier provider.*

What Is Covered

- Benefits are payable at 100%, based on Delta Dental's established fee schedule of allowed amounts: Oral examinations and prophylaxis (cleaning of teeth) but not more than twice in a calendar year (three cleanings per calendar year if you have a documented history of periodontal disease or four cleanings per calendar year for two full calendar years following periodontal surgery);
- One (1) topical application of fluoride for persons age 14 and under, unless a specific dental condition makes such treatment necessary;
- Space maintainers that replace prematurely lost teeth for persons under 19 years of age;
- Emergency treatment for temporary relief of pain;
- Fluoride trays used in the delivery of topical fluoride for enrollees undergoing radiation therapy of the head and neck due to cancer, payable once with the initial diagnosis of cancer and once thereafter with each recurrence of cancer, as medically necessary;
- Once Oral Brush Biopsy per calendar year for enrollees presenting with un-resolving oral lesions / ulcerations or having a history of behaviors placing the enrollee at risk for oral cancer. Covered services include collection of the biopsy specimen and its interpretation.

BENEFITS ARE PAYABLE AT 90%, BASED ON DELTA DENTAL'S ESTABLISHED FEE SCHEDULE OF ALLOWED AMOUNTS:

- Dental x-rays, including full mouth x-rays (but not more than once in any period of five consecutive calendar years), and bitewing x-rays once every calendar year for enrollees age 14 and younger and once every two years for enrollees age 15 and older;
- Extractions and oral surgery;
- Amalgam, silicate, acrylic synthetic porcelain and composite fillings;

- General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery;
- Endodontic (nerve and pulp) and periodontal (gum) treatment;
- Injection of antibiotic drugs by the attending dentist;
- Repair of crowns, inlays, onlays, gold fillings, bridgework or dentures; and relining or rebasing of dentures more than six months after installation, but not more than one relining or rebasing in any period of three consecutive calendar years;
- Initial installation of inlays, onlays, gold fillings, or crowns, but only when the tooth cannot be restored with an amalgam or other filling;
- Replacement of inlays, onlays, gold fillings or crown restorations on the same tooth, if at least five (5) years have elapsed since initial placement. Replacements earlier than five years are not covered;
- Cosmetic bonding of 8 front teeth when certain conditions exist for children 8-19 years of age, but not more than once in any period of three consecutive calendar years;
- Occlusal guard (maxillary or mandibular) is a covered supply for the palliative treatment of bruxism and/or acute pain of the muscles of mastication, but not more than one (1) in a five year period.
- The placement of an endosteal single tooth implant, the implant abutment, and crown, including any supportive services. Coverage does not include bone grafts or specialized implant surgical techniques.

You are responsible for the remaining 10% of the fee schedule of allowed amounts.

BENEFITS ARE PAYABLE AT 50%, BASED ON DELTA DENTAL'S ESTABLISHED FEE SCHEDULE OF ALLOWED AMOUNTS:

- Initial installation of fixed bridgework;
- Initial installation of removable dentures, including any adjustments during the six-month period following installation;
- Replacement of an existing denture or fixed bridgework, but only when:
  (a) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or,
  (b) the existing denture or bridgework cannot be made serviceable and, if it was installed under this coverage, at least five years have elapsed prior to the replacement; or,
  (c) the existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture;
- Orthodontic (teeth straightening) procedures and treatment (including related oral examinations) for any person whose course of treatment begins before age 19 subject to a maximum lifetime payment of $2,200. Coverage is not available for treatment begun after attainment of age 19.

You are responsible for the remaining 50% of the fee schedule of allowed amounts.

What is Not Covered

Covered dental expenses do not include and no benefits are payable for:

- Charges for services for which benefits are provided under other health care coverage;
- Charges for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist;
- Charges for veneers or similar properties of crowns and pontics placed on, or replacing teeth, other than the eight upper and lower anterior teeth;
- Charges for services or supplies that are cosmetic in nature;
- Charges for prosthetic devices (including bridges), crowns, inlays and onlays, and the fitting thereof which were ordered while the enrollee was not covered for dental coverage or which were ordered while the enrollee was covered for dental coverage but are finally installed or delivered to such enrollee more than sixty (60) days after termination of coverage;
- Charges for the replacement of a lost, missing, or stolen prosthetic device;
- Charges for failure to keep a scheduled visit with the dentist;
- Charges for replacement or repair of an orthodontic appliance;
- Charges for services or supplies which are compensable under a Workers Compensation or Employer's Liability Law;
- Charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the enrollee's employer;
- Charges for services or supplies for which no charge is made that the enrollee is legally obligated to pay or for which no charge would be made in the absence of dental coverage;
- Charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;
- Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature;
- Charges for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- Charges for services or supplies from any governmental agency which are obtained by the enrollee without cost by compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body;
- Charges for any duplicate prosthetic device or any other duplicate appliance;
- Charges for any services to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof;
- Charges for the completion of any insurance forms;
- Charges for sealants and for oral hygiene and dietary instruction;
- Charges for a plaque control program;
- Charges for services or supplies related to periodontal splinting.

Plan Exclusions and Limitations

If you select a more expensive service than is customarily provided, or for which Delta Dental determines there is not a valid dental need, Delta Dental's reimbursement will be based on the fee for the customarily provided service and you are responsible for the difference in cost plus applicable copays. If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services, to the extent remaining, shall be resumed. The benefit payment for orthodontic services shall be only for months that coverage is in force.

Claims

Dentist that participate with Delta Dental generally submit claims electronically to Delta Dental at the point services are received. If you receive services from a non-participating dentist, generic dental claim forms and instructions generally are available from dentists and can be submitted for appropriate processing. Claim forms are available from Delta Dental's website at **deltadentalmi.com**, by selecting the "member" tab, then accessing Delta Dental's Member's Portal or by going directly to the **memberportal.com**. You can also download Delta's mobile app, available in the App Store (Apple) or Google Play (Android) by searching "Delta Dental', to view your available benefits, review claims and conduct a dentist search.

Note that if a course of treatment is expected to involve dental expenses amounting to $200 or more, your dentist should file a description of the procedures to be performed and an estimate of the charges with Delta Dental prior to the commencement of treatment. Delta Dental will notify the dentist of estimated benefits payable, with consideration given to alternate procedures that may be performed to accomplish the desired results. By submitting a predetermination prior to receiving treatment you will have a clear understanding of your financial responsibility, and whether a different course of treatment should be considered. The predetermination process is not necessary for courses of treatment with an expected cost under $200 or for emergency treatment, routine oral examinations, x-rays, prophylaxes and fluoride treatments. Failure to file a description and estimate of your course of treatment prior to treatment could result in your being faced with higher than anticipated out-of-pocket expenses.

VISION PLAN (NON-CORE COVERAGE)

Understanding Your Benefits

(Traditional) Vision Plan At-A-Glance[12]

Benefit	Frequency	In-Network	Out-of-Network	Out-of-Area *(No network provider within 25 miles of residence)*
Vision Exam	Once each calendar year	Covered in full for Optometrist or Ophthalmologist after $7 copay	Enrollee reimbursement as follows: **Optometrist:** Scheduled amount after $7 copay **Ophthalmologist:** based on Reasonable and Customary fee after $7 copay	Enrollee reimbursement based on Reasonable & Customary fee after $7 copay, for Optometrist or Ophthalmologist
Frames	Once each calendar year	Covered in full for frames with retail value of up to $80 allowance[13] after $10 copay[14]	Enrollee reimbursement of $24 after $10 copay[14]	Enrollee reimbursement of $24 after $10 copay[14]
Eyeglass Lenses	Once each calendar year	Covered in full after $10 copay[14]	Enrollee reimbursed the carrier scheduled amount after $10 copay[14] ***Enrollee may be responsible for balance billing***	Enrollee reimbursement based on Reasonable & Customary fee after $10 copay[14]
Contact Lenses	Once each calendar year in place of regular lenses	Covered in full when medically necessary due to certain conditions after $10 copay[14], otherwise covered at scheduled amount of $80 after $10 copay[14]	Enrollee reimbursed the Reasonable and Customary fee when medically necessary due to certain conditions after $10 copay[14], otherwise reimbursed at scheduled amount after $10 copay[14] ***Enrollee may be responsible for balance billing***	Enrollee reimbursement based on Reasonable & Customary fee after $10 copay[14]
Corrective Eye Surgery	Once every four years	Enrollee reimbursement up to $350[15]		

[12] *Services include the following but are not necessarily limited to this list. Excluded services are not necessarily limited to the list provided herein.*

[13] *If eyeglass frames with a retail value greater than $80 is selected, you will be responsible for network retailers discounted price over $104.*

[14] *There is a combined annual copayment of $10 for lenses and frames.*

[15] *An enrollee receiving benefits for corrective eye surgery will be ineligible for material benefits (frames, lenses and contact lenses) for 12 subsequent months. A corrective eye surgery claim form is necessary for reimbursement.*

Traditional, In-Progression, and Full-Time Temporary employees are eligible for benefits available under the Vision Plan. **Part-Time Temporary employees** are not eligible for vision coverage.

Vision coverage provides assistance toward the cost of routine eye exams, lenses and frames through a national network of participating providers, which includes ophthalmologists, optometrists and optical facilities.

How the Plan Works

What Is Covered

Services covered under vision provisions include, but are not necessarily limited to, the items below:

- One vision examination (by an optometrist or an ophthalmologist) per calendar year including refraction, case history, coordinating measurements and tests;
- Prescription of glasses where indicated;
- Examination by an ophthalmologist, upon referral by an optometrist, within 60 days of a vision examination by the optometrist;
- Materials and professional services connected with the order, preparation, fitting and adjusting of:
    - Normal size lenses (single vision, bifocals, trifocals, lenticular) once per calendar year;
    - Number 1 or 2 tint for lenses;
    - Frame allowance up to $80 once per calendar year.
    - Contact lenses in lieu of regular lenses:
        - Following cataract surgery;
        - When visual acuity cannot be corrected to 20/70 in the better eye;
        - When medically necessary due to keratoconus, irregular astigmatism, or irregular corneal curvature;
        - Up to $80 when prescribed for any other reason than those listed above.

Limited coverage for corrective eye surgery (e.g., LASIK, PRK, RK). Upon proof of payment to a corrective eye surgery provider, the vision Carrier will reimburse an enrollee for covered expenses, up to the lesser of the provider's charges or the maximum benefit of $350 in any four-year period. The enrollee may not receive benefits for both corrective eye surgery and for frames and/or lenses (including contact lenses) in the same calendar year. If the enrollee receives benefits for corrective eye surgery in any calendar year, the enrollee will not be eligible for lenses (including contact lenses) and/or frame benefits for twelve (12) subsequent months. Nevertheless, during that time, that enrollee will be eligible for benefits for an annual eye exam, will have access to the participating provider fee schedule for non-covered services and for lenses and/or frames for which no benefit is available, and other covered family members will remain eligible for full vision benefits.

Vision Network

The vision network is made up of vision providers who have agreed to accept reimbursement based on a regional fee schedule, to meet certain contractual standards for quality, and to provide a selection of frames available to GM enrollees at no cost.

Going to a participating network vision provider will reduce your out-of-pocket expenses. You will have no copayments or out of pocket expense for covered vision services such as a routine vision exam, regular size lenses, certain designated frames that cost less than $80, or medically necessary contacts. If you choose to upgrade your frame selection by choosing a more expensive frame, the retail price of the frame will be discounted. Additionally, there are many popular non-covered lens features whose prices are discounted under the participating provider agreement.

Participating (in-network) providers can check on your eligibility, file your claim and be authorized by you to receive the reimbursement for covered services directly from the vision Carrier. Information about participating providers in your area is available by contacting *Davis Vision*.

Out of Network

Generally, if you choose to receive covered vision services from a non-participating vision provider you will have to reimburse the provider and file your own claim with the vision Carrier. The Carrier will reimburse you directly based on a fee schedule. There is one exception. Your reimbursement for vision exams provided by a non-participating ophthalmologist will be based on the reasonable and customary charge as established by the Carrier minus a $7 copay.

Out of Area

If you live more than 25 miles from a participating provider and choose to receive covered services from a non-participating provider, then your reimbursement will be based on reasonable and customary charges as determined by the Carrier.

Plan Exclusions and Limitations

What Is Not Covered

Services not covered under vision provisions include, but are not necessarily limited to:

- Any lenses that do not require a prescription;
- Medical or surgical treatment of the eye;
- Drugs or any other medication;
- Procedures determined by the Carrier to be special or unusual (e.g., orthoptics, vision training);
- Vision examinations, lenses, or frames obtained without cost to you;
- Vision examinations performed and lenses and frames ordered before you become eligible for coverage or after the termination of your coverage.

Claims

Davis Vision is the vision coverage Carrier. Network vision providers will have necessary claim forms. In addition, a claim form may be obtained from the Carrier. Complete your portion of the form and have the remaining portion completed by the provider. The completed form should be sent to the vision Carrier. Payment will be made directly to participating providers, unless you have paid all, or part, of the charges for covered services, or you received covered services from a non-participating provider. In that case, Davis will pay you the appropriate amount.

SITUATIONS AFFECTING YOUR BENEFITS

Plan Limitations

Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

The following may result in disqualification, ineligibility, denial, loss, offset, suspension, reduction or recovery of benefits. The circumstances include but are not limited to the following. Generally, your eligibility for coverage ceases at the end of the month you are last in active service. Any continuation beyond that point is based upon your employment status. Continuation opportunities are described in the *Plan Administration* > *Situations Affecting Your Benefits section.*

Benefit payments are subject to Coordination of Benefits. If another plan or program is primary, the claim should be filed first with the primary plan or carrier.

For services that require predetermination, if prior authorization is not given, and you elect to have the services performed, such services will be payable at 80% of the Carrier's approved amount (see *Common Terms* for more information).

If any benefits are paid for non-covered services or on behalf of ineligible dependents, you will be notified, and you will be responsible for repaying the overpayment. If you should fail to repay the overpayment promptly, the Health Care Program will deduct the amount from your wages or benefits, or may recover the overpayment by other legal means.

If a Medicare eligible surviving spouse of an active enrollee who was not retirement eligible fails to enroll in Medicare Part B, the surviving spouse will not be eligible for company contributions for health care coverage.

Effect of Medicare

If You Are Actively Working

Medicare Part A (Hospital Insurance) provides coverage for inpatient care, skilled nursing facilities, hospice and home health care. Generally, if you have paid FICA taxes to earn 40 quarters (typically 10 years) and are a U.S. citizen or have met the legal residency requirements, you are eligible for premium-free Medicare Part A, which can supplement the GM Program. Medicare Part B (Medical Insurance) provides coverage for doctor's services and outpatient care. You are required to pay a monthly premium for Part B. If you are actively working, you can delay enrollment in Part B until retirement, regardless of age, without incurring a late enrollment penalty fee.

When you become eligible for Medicare at age 65 and you choose to continue working, the GM Benefits & Services Center will alert you to your Medicare eligibility approximately three months prior to you becoming age 65. Enrollment in Medicare is not necessary if you remain actively working. It is important to note, if you continue to work past the age of 65, Social Security will not continue to notify you of your eligibility to enroll for Medicare. It is your responsibility to contact your local Social Security Administration office to apply for Medicare. It is recommended you do so prior to terminating your employment with GM.

You have resources to help you avoid any unnecessary costs or if you need help signing up for Medicare Part B:

- Centers for Medicare & Medicaid Services: www.cms.gov
- Medicare: www.medicare.gov (1-800-633-4227)
- SSDC Services Corporation: www.ssdcservices.com (1-800-374-9950; TTY users call 711)

If You Become Disabled

If you are on a disability-related leave of absence, your health care coverage will change how the Program pays for your health care services. For the first six months while you're on disability, the GM Health Care Program will be the primary payer of your health care services. Once that six-month period ends and you and/or your covered dependents are eligible or become eligible for Medicare, Medicare becomes the primary payer of health care services, and GM becomes the secondary payer.

If you do not return to work, and you and/or your covered dependents are eligible for Medicare, the GM Health Care Program's provisions require your Plan's carrier to adjust claims and pay as if you are enrolled in Medicare Part A and Part B. The GM Health Care Program will make limited or no payment of claims once you are eligible for Medicare, even if you are not enrolled. If you and/or your covered dependents don't enroll, or disenroll in Medicare Part A and Part B, you could have high out-of-pocket expenses (up to 80%).

If you are on a disability leave of absence and are eligible to enroll in Medicare, Medicare may become the primary payer of your medical claims during such leave.

Most people sign up for Medicare when they're first eligible. Generally, there are risks to signing up later, like a gap in your coverage or having to pay a penalty. If you miss your 7-month Initial Enrollment Period (IEP), you may have to wait to sign up and pay a monthly late enrollment penalty for as long as you have Part B coverage. The penalty goes up the longer you wait.

Here are some online government resources to help you learn about Medicare:

- Centers for Medicare & Medicaid Services: www.cms.gov
- Medicare: www.medicare.gov **(1-800-633-4227)**

When you become eligible for Medicare, signing up only takes a couple steps:

1. Contact your local Social Security Administration office to apply for Medicare Part A and Part B coverage. You can find the office closest to you at www.ssa.gov/locator/.
2. When you receive your Medicare card, call the GM Benefits & Services Center immediately at **1-800-489-4646** from 7:30 a.m. to 6:00 p.m. Eastern Time, Monday through Friday, to update your status. TTY users call **711**. They'll ask you for the coverage effective date, which you'll find on your Medicare card.

General Motors has partnered with SSDC Services to assist you with determining if you're eligible for enrollment in Medicare Part B if on a disability leave of absence. They can also provide required documentation for enrollment, when applicable. There is no cost to you for this service. SSDC Services can be reached at **1-800-374-9950**, option 5; TTY users call 711 or you can visit their website at www.ssdcservices.com.

If You Have End-Stage Renal Disease (ESRD)

If you or one of your dependents have end-stage renal disease (ESRD), or undergo a kidney transplant, you (or your dependent) may be eligible for Medicare coverage prior to age 65. For the first 30 months after being diagnosed with ESRD, also referred to as the "coordination period," your GM health care plan is the primary payer for your health care services. After the 30-month coordination period has ended, Medicare will become the primary payer of your health care services. If you (or your dependent) don't enroll in Medicare Part A and Part B by the end of the ESRD coordination period, the provisions of the Program require the Carrier to adjust claims and pay as if you're enrolled in Medicare coverage. This can result in limited payment or no payment by the GM Health Care Program and the possibility of high out-of-pocket expenses.

It is important to consider enrolling in Medicare even if you've received a transplant. Please be advised that governmental guidelines state that a transplant isn't (considered) successful for 36 months from the date of the transplant. Medicare remains the primary payer until the transplant is deemed successful.

Coordination of Benefits

A coordination of benefits (COB) provision is included in all coverages under the Program. The purpose of this provision is to avoid duplicate payment of benefits in the event an individual is covered by more than one employer's health care plan. For example, if expenses are incurred by your spouse who is covered by another plan, the other plan may have the primary responsibility of payment. If so, your overall coverages may be enhanced and the cost to the GM Program will be reduced.

If COB is done properly, you and your dependents will receive no fewer benefits than you would have received under the GM Program alone and you may receive more or enhanced benefits.

When the Health Care Program is secondary, the following provision apply:

- Certain requirements under the GM Program, such as predetermination of hospital admissions, are waived. If you are enrolled in an HMO option, you are required to obtain services from the HMO panel of providers, or obtain a referral from the HMO in advance, for services to be covered (you should always check with the HMO);

- Only those services covered under the GM Program will be considered for additional benefit payment. For example, if the primary plan covers office visits, no additional payment will be considered for a TCN enrollee, because office visits are not covered under the GM Program TCN option.

Note: Enrollees should always choose the maximum level of benefits available under the Primary Plan to enhance benefits available through COB.

The Carrier should be notified of other plans or programs which may cover you or your dependents. No notice is required for insurance policies issued in your name, or a dependent's name, for which you pay more than ½ the cost. In some cases, you may be required to provide the Carriers with additional information.

Once you have identified whether other coverage is involved, you should determine which plan is primary for the individual having a claim. If another plan or program is primary, the claim should be filed first with the primary plan or carrier. If the primary plan does not cover the health care expenses in full, the unpaid balance can be considered under the GM Program. You should provide your GM Carrier with information on the payments made by the other plan or authorize the other carrier to do so. From that point, COB is handled between the carriers. If the remaining balance is for services covered under the GM Program, it will pay the balance, up to the maximum permitted under the GM Program.

Recovery of Benefit (Claim) Overpayments

If any benefit paid to you or on your behalf (or to one of your dependents or on their behalf) should not have been paid, or should have been paid in a lesser amount and you fail to promptly repay the amount, to the extent permitted by applicable law the overpayment or loan may be recovered from any monies then payable, or which may become payable, to you in the form of wages or benefits, except health care benefits, payable under a GM benefit Plan. Health Care Program overpayments may be recovered from wages or other benefit Plans or Programs, as appropriate. Overpayments under other Plans or Programs will not be offset against health care benefits.

If you wish, you may direct GM to withhold an amount up to 10% of your (1) Personal Savings Plan, or (2) monthly pension benefit, to repay the benefit overpayment or the full amount of the loan.

Reimbursement for Third Party Liability (Subrogation)

Occasionally a person may sustain an injury and incur health care expenses because of another party's wrongdoing. If benefits are paid under the GM Program, and it is later determined that another party should have been responsible for the expenses, the GM Program is entitled to reimbursement.

Subrogation is the legal process used to seek reimbursement for claims that have been paid when expenses are incurred because of another party's actions or inactions. While GM does not suspend coverage while liability is being determined, the GM Plan should not bear the financial responsibility if another party is responsible. In that way, financial liability remains where it belongs, with the party responsible incurring the expenses and GM Program costs are reduced.

The Plan has the right of reimbursement from any recovery by judgment, settlement, or otherwise, in which you, your estate, or your dependents may receive or be entitled to receive from any source, including but not limited to, liability or other insurance covering third party, and direct recoveries from liable parties.

If you, or one of your covered dependents, are involved in such a situation, you are required to provide the Plan with information regarding the event. Should you or your dependent receive a letter of inquiry from GM's subrogation vendor, you must provide all requested information to help assure that the Plan does not pay for expenses caused by a third party.

If you, or any of your dependents, receive payment for medical expenses, you will be required to reimburse the Plan, in an amount not in excess of the benefits paid by the Plan. The Plan shall have a first priority lien on any recovery from a third party. The Plan must be repaid in full of expenses incurred regardless of whether the settlement or judgment specifically designates the recovery, or a portion of the recovery as medical expenses.

If you are enrolled in an HMO, this provision does not apply to you. The HMO will utilize its own subrogation and reimbursement process.

APPEALS

Health Care Mandatory Appeal Procedure

A mandatory appeal procedure has been established for review of denials of eligibility and/or of claims for benefits under the Health Care Program. When services are received, the Carrier will provide you with an Explanation of Benefits (EOB) which will show payment of benefits and any specific reasons for a denial of benefits. If there is a denial of benefits you may appeal to the Carrier at the address provided in the EOB. The initial written request to review the denied claim is the Mandatory Appeal Procedure. The response that you receive from the Carrier will refer you to the Program provisions on which the denial is based. If your appeal is related to an eligibility issue, you should send it to the GM Benefits & Services Center, P.O. Box 770003, Cincinnati, OH 45277-1060 or call the GM Benefits & Services Center at 1-800-489-4646.

After you receive notice that a claim was denied, in whole or in part, you have 180 days to make a written request to the applicable Carrier to have the claim reviewed. If a claim meets the definition for urgent care under applicable federal regulations, the request may be submitted by telephone. As part of the review, you may submit any written comments that may support the claim. A written decision on the request for review will be furnished to you as follows:

Urgent Care Claims – In the case of a claim involving urgent care, as defined by applicable regulations, the Carrier shall notify you of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

Pre-service Claims – In the case of a pre-service claim, as defined by applicable regulations, the Carrier shall notify you of the benefit determination on review within a reasonable period of time, appropriate to the medical circumstances, but not later than 30 days after receipt by the Carrier your request for review of an adverse benefit determination. In the case of a Carrier that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the Carrier of your request for review of the adverse benefit determination.

Post-service Claims – In the case of a post-service claim, as defined by applicable regulations, the Carrier shall notify you of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt by the Carrier of your request for review of an adverse benefit

determination. In the case of a Carrier that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the Carrier of your request for review of the adverse benefit determination.

The time periods specified for each category of claims above may be extended in accordance with applicable regulations. The written decision on the review will include the specific reasons for the decision and will set forth specific reference to Program provisions upon which the decision is based. If the review by the Carrier results in an adverse determination, you may initiate an action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

As an alternative to immediately initiating such civil action, if you receive a final determination denying eligibility for coverage under the Program or a claim for benefits, you may request further review by the Plan Administrator under a voluntary review process (as described below). In connection with an applicable voluntary review process, the Program:

(1) Waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to such process; and,

(2) Agrees that any statute of limitations or other defense based on timeliness is tolled during the time such review is pending.

External Review Process

Following the completion of the Mandatory Appeals process, and if the benefit denial was upheld, you may further appeal through the External Appeals Process. Effective January 1, 2012, pursuant to the Patient Protection and Affordable Care Act (PPACA), individuals may pursue an external review through the Independent Review Organization (IRO).

When a determination is provided to your Mandatory appeal, you will be provided information on how to pursue the next level of the appeal through the IRO. Following receipt of the notice to uphold the denial, you will have four months to make a request of the Carrier for an external review. Upon receipt of the request, the Carrier will send the case to an IRO. Once received, the IRO will make a determination of the claim, based on whether the case involves "Medical Judgement." If the determination is "yes," the IRO will make a determination to either uphold or overturn the Carrier's decision. If the determination of medical judgement is "no," then the IRO will notify the Carrier that a determination cannot be made and the case will be referred for a Voluntary Review. If the IRO is able to make a determination, the claim will not be reviewed further under the Voluntary Review process.

Note: The External Review process does not apply to employees and their eligible dependents enrolled in the following Plans: Temporary Employee Health Care Plan, or Vision Plan. The External Review process is also not available to employees enrolled in an HMO, or appeals to determine eligibility in the Plan.

Voluntary Review Process

The following describes the steps followed by the voluntary review process:

Step 1. Following receipt of a final determination from the Control Plan, Carrier, or IRO with regard to the appeal of a denial of a claim in full or in part, you may request the local union benefit representative to review the disputed claim with a designated Plans Workforce representative by writing to the GM Benefits & Services Center, P.O. Box 770003, Cincinnati, OH 45277-1060.

If requested to do so, the Plans Workforce representative will endeavor to obtain additional information from the Control Plan or Carrier regarding the disputed claim. The Control Plan or Carrier will advise the Plans Workforce representative what, if anything, can be done to support your claim for payment of benefits.

Step 2. If local union benefit representatives contest the position of the Control Plan or Carriers as reported by the Plans Workforce representatives, they may refer the case to the International Union for review with the Plan Administrator.

Step 3. The International Union may review the disputed claim with the Plan Administrator, Control Plan or Carrier. At the request of the International Union, the Plan Administrator will request either the Control Plan or Carrier, as appropriate, to review such claim.

Step 4. The Control Plan or Carrier will be requested to report in writing to the Plan Administrator and International Union its action as a result of such review. If payment of the claim is denied in full or in part, the Control Plan or Carrier will be requested to include in its report the pertinent reasons for the denial.

Disputes related to health care claims or questions of coverage through a health maintenance organization may be reviewed in the same manner as outlined in the preceding four steps, as applicable, subject to the following:

1. Following the denial of a claim, an enrollee must file any appeal with the health maintenance organization through the member services department (or a similar department). Health maintenance organizations provide members with a formal procedure through which members can have denied claims reviewed. Formal appeal procedures within health maintenance organizations vary, but usually include multiple steps in which a denied claim is reviewed.
2. When the formal appeal procedure has been exhausted, upon request, the health maintenance organization will be required to provide the Plan Administrator or the International Union with information concerning its actions as a result of the findings of the investigation.

ADDITIONAL INFORMATION

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

This notice applies to you if you are covered under the General Motors Health Care Program for Hourly Employees. This notice contains important information about your right to COBRA Continuation coverage, which is a temporary extension of coverage under the Program. This notice generally explains COBRA Continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA Continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Program when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Program and under federal law, you can request a copy of the Plan Document from the GM Benefits & Services Center by calling 1-800-489-4646.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Program coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage is lost because of the qualifying event. Under the Program, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Program because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Program because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Program because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Program as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to General Motors, and that bankruptcy results in the loss of coverage of any retired employee covered under the Program, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Program.

When is COBRA Coverage Available?

The Program will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Call the GM Benefits & Services Center at 1-800-489-4646.

How is COBRA Coverage Provided?
Once the GM Benefits & Services Center receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage may be available for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which their employment terminates, COBRA continuation coverage for their spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Program is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0020 or call the GM Benefits & Services Center at 1-800-489-4646.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences a second qualifying event during the initial 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Program. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Program as a dependent child, but

only if the event would have caused the spouse or dependent child to lose coverage under the Program had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0020 or call the GM Benefits & Services Center at 1-800-489-4646.

If You Have Questions
Questions concerning your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at dol.gov/ebsa.

Keep Your Plan Administrator Informed of Address Changes
In order to protect your family's rights, you should keep the GM Benefits & Services Center informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the GM Benefits & Services Center.

Contact Information
You should contact the GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0020 or call the GM Benefits & Services Center at 1-800-489-4646, Monday through Friday between 7:30 a.m. and 6:00 p.m. Eastern Time, to speak with a Customer Service Associate.

Conversion Privilege

If you choose to not continue your coverage under COBRA, or if your continuation of coverage under COBRA ends, you may have the option of converting your current health care coverage to an individual policy. To determine the availability of a conversion policy, you must contact your current carrier within 30 days of your coverage end date.

Newborns' and Mothers' Health Protection Act of 1996

Under federal law, medical plans may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery without complications, or less than 96 hours following a caesarean section, or require that a provider (e.g., a doctor or hospital) obtain authorization from the plan or the insurance issuer (including an HMO or PPO) for prescribing a length of stay which is not more than the above periods. Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above respective periods.

Women's Health and Cancer Rights Act of 1998

Under federal law, GM is required to notify plan participants of the Women's Health and Cancer Rights Act of 1998, which requires group health care plans to provide certain benefits for breast reconstructive surgery following a mastectomy.

Under federal law, participants and eligible dependents who receive benefits in connection with a mastectomy, and who elect breast reconstruction, will be provided coverage under the plan, in a manner determined by consultation with the attending doctor and the patient for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Coverage and benefits are subject to the plan's applicable copayments, coinsurance, deductibles and other limitations and exclusions, including limitations for reasonable and customary charges. For a complete description of benefits, limitations and exclusions, please see the *Medical Plan* section.

Patient Protection and Affordable Care Act (PPACA)

The Plan Administrator believes that the medical plan offered to Temporary employees under the General Motors Health Care Program for Hourly Employees is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at Mail Code 482-C36-D48, 300 Renaissance Center, Detroit, MI 48265-3000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272.

No Surprises Act of the 2021 Consolidated Appropriations Act

Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Provider for any covered service is higher than the maximum approved amount determined by the Plan, participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion. Continuity or Transition of Care In the event you are a continuing care/transition of care patient receiving a course of treatment from a Provider that has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, you shall have the following rights to continuation/transition of care.

The Plan shall notify you in a timely manner, but in no event later than 7 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that you have rights to elect continued transitional care from the Provider. If you elect in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when you cease to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who: 1. is undergoing a course of treatment for a serious and complex condition from a specific Provider, 2. is undergoing a course of institutional or inpatient care from a specific Provider, 3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery, 4. is pregnant and undergoing a course of treatment for the pregnancy from a specific Provider, or 5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider. Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the participant for any amounts above the Plan's benefit amount.

No Surprises Act – Emergency Services and Surprise Bills

For non-contracted Provider claims subject to the No Surprises Act ("NSA"), participant cost-sharing will be the same amount as would be applied if the claim was provided by a contracted Provider and will be calculated as if the Plan's Approved Amount was the recognized amount, regardless of the Plan's actual maximum approved amount. The NSA prohibits Providers from pursuing participants for the difference between the maximum approved amount and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost sharing amounts will accrue toward deductibles and out-of-pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider. Claims subject to the NSA are those which are submitted for: Emergency Services; Non-emergency services rendered by a non-contracted Provider at a contracted Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and Covered non-contracted air ambulance services.