UAW RETIREE Medical Benefits Trust

2026 HEALTH CARE BENEFIT HIGHLIGHTS

At the UAW Retiree Medical Benefits Trust, our mission is simple: to ensure every Trust member—now and in the future—has access to high-quality healthcare benefits without compromising affordability. As you get older, healthcare can become more complex: chronic conditions may arise and specialized care might become necessary. That's why we're committed to providing programs and services that adapt to your evolving needs—delivering the best value through every stage of retirement.

Highlights for 2026

- **No cost share changes for any healthcare plans**
- **No increases to drug copays**
- **100% coverage for one (1) colonoscopy per year***
- **Expanded access of coverage for in-home physical and speech therapy services**
- **$0 copay for all vaccines recommended by the USPSTF—at the pharmacy or doctor's office**
- **Increase to both the Trust OTC and HRA annual amounts**

*** May differ for Kaiser plans, see plan materials for coverage**

We hope these improvements, whether increased annual allowances for your HRA and OTC benefits or enhanced access to care, help you enjoy life more comfortably and confidently.

Please take time to review this booklet for full details on your 2026 benefits. Resources—including video guides—are available at **uawtrust.org/annualenrollment.** If you have further questions or need to make changes to your coverage, contact Retiree Health Care Connect (RHCC) at 866-637-7555, Monday through Friday, 8:30 a.m. to 4:30 p.m., Eastern Time.

If you want to change plans, in order for it to be effective January 1, 2026, be sure to contact RHCC between Tuesday, September 2, and Friday, October 31, 2025.

We wish you the best in retirement and a healthy year ahead.

UAW Retiree Medical Benefits Trust

Medicare Cost Share[1] 2026

No Change

	MA PPO Medicare Advantage PPO	TCN Traditional Care Network	HMO Health Maintenance Organization
Monthly Contribution	$0 Single $0 Family	$0 Single $0 Family	$0 Single $0 Family
Deductible (Amount you pay annually before the plan covers 100% of covered costs)	$0 / Person	$175 Single $350 Family	$250 Single $500 Family
Primary Care Physician (PCP) Office Visit	$0 Copay / Visit	$0 Copay / Visit	$15 Copay / Visit±
Specialist Office Visit	$10 Copay / Visit	$10 Copay or 20% (lesser of)	$25 Copay / Visit±
Urgent Care (Includes retail health clinics)	$15 Copay / Visit	$40 Copay / Visit	$15 Copay / Visit±
Emergency Room (Waived if admitted)	$50 Copay / Visit	$125 Copay / Visit	$50 Copay / Visit

No changes to cost share for Protected members in 2026, refer to plan materials

[1]Reflects in-network costs

±Members in Kaiser plans may have different copays

Non-Medicare Cost Share[1] 2026

No Change

	ECP Enhanced Care PPO	HMO Health Maintenance Organization
Monthly Contribution	$0 Single $0 Family	$0 Single $0 Family
Deductible (Amount you pay annually before the plan covers 100% of covered costs)	$175 Single $350 Family	$250 Single $500 Family
Primary Care Physician (PCP) Office Visit	$0 Copay / Visit	$15 Copay / Visit±
Specialist Office Visit	$10 Copay / Visit	$25 Copay / Visit±
Urgent Care (Includes retail health clinics)	$40 Copay / Visit	$40 Copay / Visit±
Emergency Room (Waived if admitted)	$125 Copay / Visit	$125 Copay / Visit

No changes to cost share for Protected members in 2026, refer to plan materials

[1]Reflects in-network costs

±Members in Kaiser plans may have different copays

Prescription Drug Coverage* 2026

No Change

	Retail (One Month)	Mail-Order (90-Day)
Tier 1	$0	$0
Tier 2	$33	$33
Tier 3	$115	$115

Specialty medications dispensed in one-month increments

*Members in Kaiser plans have different copays

New Prescription Drug ID Card—All Medicare Members

Beginning January 1, 2026, Optum Rx will be the group-sponsored Medicare prescription drug plan for all Medicare members, regardless of health plan (except Kaiser plans). All members will get a new prescription ID card in December. **No action is required.**

The plan will function the same as the current Optum Rx prescription plan—with a three-tier copay structure and access to a 90-day mail-order program. Please note, this means members enrolled in the Blue Cross Medicare Advantage or UnitedHealthcare Medicare Advantage plan will get a **separate prescription ID card** for prescriptions. Members will need to use this new prescription ID card when filling prescriptions at the retail pharmacy after January 1.

New Prescription Drug ID Card—All Non-Medicare Members

Optum Rx will send new prescription drug ID cards to all non-Medicare members regardless of health plan (except Kaiser plans). All members will get a new prescription ID card in December. **No action is required.** There is no change to the program. Members will need to use this new prescription ID card when filling prescriptions at the retail pharmacy after January 1.

New Medical ID Card—UnitedHealthcare MA, Blue Cross MA, Blue Cross ECP

Members currently enrolled in the UnitedHealthcare Medicare Advantage (MA) plan, Blue Cross Medicare Advantage (MA) plan and the Blue Cross Enhanced Care PPO (ECP) plan will receive new medical ID cards in December.

Be sure to use the new medical ID card for all medical services after January 1, 2026.

Over-the-Counter (OTC) Benefit Enhancements

Beginning January 1, 2026, the annual allowance for the over-the-counter (OTC) benefit **will increase to $400 per member**. There are no additional changes to the program. You continue to have the option to order by phone or online through CVS. You can also purchase in-store at any participating OTC Network retail locations.

New flex cards and catalogs **will not** be mailed. Your current card will be reloaded with funds on January 1. Use your current flex card and catalog for purchases in 2026. The website and in-store are the easiest ways to find a current list of qualifying items. To order products, visit the online portal at **uawtrust.org/otcbenefit** or call 844-487-2770. You can also purchase items at more than 68,000 retail stores with the OTC Network logo. You are not limited to CVS stores for in-store purchases.

Don't forget—any unused dollars as of December 31, 2025, **will not roll over** to 2026.
Be sure to use all your annual allowance before the end of the year.

New Health Reimbursement Arrangement (HRA) Plan

Beginning **May 1, 2025,** the Trust added a Retiree-Only Health Reimbursement Arrangement (HRA) for eligible members. The HRA is a healthcare spending account funded exclusively by the Trust. The HRA is administered by WEX, a company offering HRA programs for employer groups. The Committee determines the annual funded amount. For 2025, the funded amount is $600. **For 2026, the funded amount is $1,000.** Expenses covered under the HRA generally include medical expenses like office visit copays, deductibles and coinsurance, dental and vision costs, hearing aids, prescription drug copays and Medicare premiums. Expenses incurred from January 1, 2025, or when first eligible, if later, to December 31, 2025, can be submitted for reimbursement under the HRA for the 2025 plan year. Unused HRA money is not rolled over to the next year and is forfeited.

Eligibility

Each Trust healthcare contract holder is eligible for the HRA. Dependents, including spouses, do not receive a separate HRA benefit. Dual coverage households must have separate contracts to each receive an HRA.

Eligible members will be automatically enrolled as an HRA participant; **no action is required.**

The HRA is only available to the contract holder—retiree or surviving spouse. This means there is only one HRA benefit per eligible household. An individual cannot receive an HRA as both a retiree and a dependent. Active employees of an auto company are not eligible for an HRA.

Funded Amount

Beginning May 1, 2025, each eligible **participant's HRA was credited with $600.** This amount is available to reimburse eligible medical expenses and/or Medicare premiums incurred between **January 1, 2025, and December 31, 2025.** It is important to note, any balance that remains at the end of the plan year will be forfeited if unused. Requests for reimbursement for costs incurred in 2025 must be submitted no later than April 30, 2026.

For subsequent plan years, each participant's HRA will be credited on January 1 of the plan year. **On January 1, 2026, the credited amount will be $1,000.** The amount credited will be determined by the Committee and communicated by the Trust to members each year.

Eligible Expenses

Participants can use HRA money for their own medical expenses or those of any tax-eligible dependent, including their spouse or other dependents as specified in the Internal Revenue Code. Only eligible medical expenses will be reimbursed. IRS Publication 502 describes eligible medical expenses, which generally include: medical, dental, and vision expenses, including prescription drug copays. Additionally, HRA qualified expenses include Medicare Part A, B, and D premiums, and/or Income-Related Monthly Adjustment Amount (IRMAA) payments.

Expenses must have been incurred during the plan year, which runs from January 1 to December 31 of the particular year. An expense is incurred on the date when the care or service giving rise to the expense is provided. The date of billing or payment does not control.

Eligible medical expenses can be paid directly using a debit card or reimbursed through a claim process. WEX, the claims administrator, may reimburse eligible medical expenses through a check or, if you elect and establish, direct deposit. Reimbursements will be issued as scheduled by the HRA administrator, WEX.

You will be required to re-pay the HRA plan for reimbursements that the HRA administrator determines are unsubstantiated.

Expense Reimbursement

Two HRA debit cards are mailed to participants by WEX. Before use, the debit card must be activated using the process indicated on the card. The HRA debit card can be used to access funds in the HRA for eligible medical expenses. Participants can use the card at the point-of-sale for HRA reimbursable medical expenses (such as a prescription copay or doctor's office visit copay) when incurred at a qualified provider or similar eligible merchant type. New cards will NOT be mailed each year, and provided cards will be reloaded at the commencement of each year. Access to ATMs and cash back is not allowed with the debit card.

To use the card, swipe the card at a provider or pharmacy to pay for eligible medical expenses. The card operates in the same manner as a credit card and a PIN is not required. The card may be declined if used at a merchant that does not offer eligible medical expenses. Members should retain documentation to substantiate debit card transactions and verify appropriate use in the event of an audit. Documentation should include itemized receipts; credit card receipts are not sufficient substantiation.

Participants wishing to use the debit card must certify that they will:

(i) only use the debit card to pay for eligible medical expenses;
(ii) only use the debit card for expenses incurred by eligible dependents;
(iii) will not use the debit card for expenses that have already been reimbursed;
(iv) provide required documentation of the expense to the HRA administrator;
(v) will not seek reimbursement under any other health plan for expenses paid for with the debit card; and
(vi) abide by all other terms and conditions of the debit card program.

Participants can set up an online account to manage the HRA benefit. To set up an online account the participant will need their debit card. The online account allows you the option to file online claims, submit reimbursement for Medicare premiums, set up direct deposit, view claims statuses, and upload receipts.

To be reimbursed for eligible medical expenses incurred, you must submit a completed claim form along with documentation to the HRA administrator, WEX. Claims can be submitted online or by using a paper claim form submitted using fax, email, or mail. Online instructions were provided in the HRA brochure mailed to members. Claim forms can also be obtained at the following: **uawtrust.org/hrabenefit.** The documentation must be from an independent third party (for example, an itemized bill, receipt or an Explanation of Benefits) showing:

(i) the date of service;
(ii) a description of the service provided;
(iii) the cost of the service;
(iv) name and location of care provider; and
(v) name of person who received care.

Claims and Appeals

Request for reimbursement must be submitted during the plan's claims submission period. Your HRA balance will be available to reimburse eligible medical expenses incurred through December 31 of the plan year. You will have until April 30 of the following plan year to submit reimbursement claims to WEX, the HRA administrator.

Appeals should be submitted to the plan administrator, WEX, by mail, email or online. WEX will establish and communicate rules regarding the submission of claims and appeals.

Mail:
WEX
PO BOX 2926
Fargo, ND 58108-2926

Email & Online:
forms@wexhealth.com
benefitslogin.wexhealth.com

The HRA administrator, WEX, reserves the right to deny claims for lack of funds and may also offset claims from future amounts if your HRA account is overdrawn.

NOTE: The HRA administrator, WEX, has full discretion to determine whether an expense submitted is eligible. The HRA administrator may deny a claim that is not timely submitted and/or not properly substantiated.

Questions About the HRA Plan?

If you have questions about the HRA plan, please contact WEX at 844-440-4300, Monday through Friday, 7 a.m. to 10 p.m., Eastern Time.

Learn more about the HRA benefit at **www.uawtrust.org/hrabenefit**

Coverage for One (1) Colonoscopy Per Year—Preventive or Diagnostic

Effective January 1, 2026, all health plans will provide one (1) colonoscopy per year, covered at 100%, with no cost sharing or deductible, regardless of whether the procedure is deemed preventive or diagnostic, and whether performed in network or out of network (for plans with out-of-network benefits). Please note this change may differ for members enrolled in a Kaiser plan; refer to your plan materials for coverage.

Expanded Coverage for In-Home Physical and Speech Therapy Services

Beginning January 1, 2026, all health plans are being enhanced to provide in-home physical therapy (PT) and speech therapy (ST) services delivered by in-network providers, covered at 100%. This only applies when services are provided by an in-network PT or speech language pathologist (SLP). Services are covered at 100%, and not subject to your deductible (for plans with a deductible).

Expanded Vaccine Coverage

Starting January 1, 2026, all health plans will amend coverage to ensure all United States Preventive Services Task Force (USPSTF) A or B Immunization Recommendations are covered at 100%. Common USPSTF-recommended vaccines are flu, Tdap—which is the tetanus, diphtheria and pertussis shot—pneumococcal and shingles. Eligible plan members pay $0 out-of-pocket for the vaccine itself and for administration. However, office visit copays may apply if done in the doctor's office.

Termination of Evolent Program (formerly Vital Decisions)

Effective June 30, 2025, the Evolent Program (formerly Vital Decisions) is no longer available to Blue Cross Traditional Care Network (TCN) or Enhanced Care PPO (ECP) members. The Evolent Program, which provided support for advance care planning (ACP), has eliminated its ACP product. Trust members can receive advance care planning information and support from their physicians and through UAW Legal Services.

IMPORTANT!!!

What to Expect This Year

There will be a lot of communications coming to you this fall. Because of new ID cards and other changes, members will receive numerous communications from the Trust, as well as carriers this fall. Some of these communications are **required by law**, while others seek to advise members on their health and benefits, as well as tips for a smooth transition into the new year.

Please note, members may receive termination notices, as well as confirmation of coverages.

There will be **no gap in coverage for members** unless they contact RHCC to opt-out of Trust healthcare or prescription drug coverage.

Good Tips

Know Your Health Plan's Provider Network

When considering your healthcare plan, it's important to **understand how provider networks work.** Carriers—such as Blue Cross, UnitedHealthcare, and others—operate with different networks for each of their plans. This means the list of participating providers may vary depending on the plan you select.

Providers, including doctors, hospitals, and clinics, **can join or leave a network at any time.** That's why it's essential to regularly verify your provider's network status. If a provider agrees to see you but is not in your plan's network, you may be responsible for higher out-of-pocket costs.

And keep in mind, providers who are not part of your plan's network are not obligated to treat you. This means **they can refuse to treat you** even at higher costs. To avoid unexpected costs or denied visits, always **confirm your provider's participation** by using the online provider lookup tool or by contacting your health plan directly.

Utilize Your OTC and HRA Annual Allowance

Remember, any unused dollars from your Trust OTC Benefit as of December 31, 2025, will **not roll over** to 2026. **Be sure to use all of your annual allowance before the end of the year.**

Your HRA balance will be available to reimburse eligible medical expenses incurred through December 31 of this year. Any 2025 unused dollars from your Trust HRA Benefit will not roll over to your 2026 annual allowance. You will have until April 30, 2026, to submit reimbursement claims to the HRA administrator for any eligible 2025 qualified health care expenses.

Need Help?

Retiree Health Care Connect (RHCC) is available at 866-637-7555
Monday through Friday, 8:30 a.m. – 4:30 p.m., Eastern Time

Update your contact information, including your email address

Ask questions and compare plans

Make changes to your health care plan. For plan changes to be effective January 1, call between **September 2** and **October 31**

NOTES

Addendum to the Benefit Highlights, Schedule of Benefits and Summary Plan Description Previously Published

If there is any conflict between this document and previously published documents, the plan document will govern. The Committee reserves the right to interpret, amend or terminate the plan of healthcare benefits at any time.

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