

Supplemental Agreement

Covering

**HEALTH CARE
PROGRAM**



Exhibit C
to
AGREEMENT
between
the
UAW
and
GENERAL MOTORS LLC
dated
October 16, 2019

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EXHIBIT C

SUPPLEMENTAL AGREEMENT

(Health Care Program)

October 16, 2019

2019 SUPPLEMENTAL AGREEMENT **(HEALTH CARE PROGRAM)**

On this 16th day of October 2019, General Motors LLC, hereinafter referred to as the Company, and the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, hereinafter referred to as the Union, on behalf of the employees covered by the Collective Bargaining Agreement of which this Supplemental Agreement becomes a part, agree as follows:

Section 1. Establishment of Program

Subject to the approval of its Board of Managers the Company will establish an amended Health Care Program, hereinafter referred to as the Program or this Program, a copy of which is attached hereto as Exhibit C-1 and made a part of this Agreement to the extent applicable to the employees represented by the Union and covered by this Agreement as if fully set out herein, including supplemental plans as reflected in Appendix F but to exclude Appendices G and H, modified and supplemented, however, by the provisions hereinafter. In the event of any conflict between the provisions of the Program and the provisions of this Agreement, the provisions of this Agreement will supersede the provisions of the Program to the extent necessary to eliminate such conflict.

In the event that the Program is not approved by the Board of Managers of the Company, the Company, within 30 days after any such disapproval, will give written notice thereof to the Union and this Agreement shall thereupon have no force or effect. In that event the matters covered by this Agreement shall be the subject of further negotiation between the Company and the Union.

In the event the initiation of any benefit(s) or coverage(s) described in the Program does not prove practicable or if the carriers are unable to provide such benefit(s) or coverage(s) on the dates stipulated in such Program, the Company in agreement with the Union will provide new benefit(s) and/or coverage(s) as closely related as possible and of equivalent value to those not provided.

Section 2. Financing

(a) The Company agrees to pay the contributions due from it for the Program in accordance with the terms and provisions of Exhibit C-1.

(b) Company contributions for coverages, continued while on layoff pursuant to the provisions of Article III, Section 3(c) of the Program shall be in accordance with this subsection (b) as follows:

(1) In any month during which the employee is continuously laid off for one of the reasons set forth in Article IV, Section 13 of this Program, the Company shall provide continued coverages as set forth in the following Schedule (subject to payment by the enrollee of any required contributions):

SCHEDULE OF CONTINUANCE OF COVERAGES FOR EMPLOYEES LAID OFF AS DEFINED UNDER THIS PROGRAM¹	
Years of Seniority² As of Last Day Worked Prior to Layoff	Maximum Number of Months for Which Coverage Will be Continued Without Cost to Employee
Less than 1	1
1 but less than 2	4
2 but less than 3	6
3 but less than 4	8
4 but less than 5	10
5 but less than 10	13
10 and over	25

¹ Applicable to an employee at work on or after October 28, 2019. For employees who last worked prior to October 28, 2019, the provisions of the appropriate agreement apply.

² For the purpose of this Schedule, Seniority is defined under Article IV, Section 20 of the Program.

(2) With respect to any period of continuous layoff, changes in an employee's seniority subsequent to the date layoff begins shall not change the number of months of Company contributions for which such employee is eligible.

(3) Notwithstanding the provisions of Article III, Section 3(b) of the Program with respect to the requirement of unbroken seniority for continuation of coverages while on layoff, such provisions shall not prevent the continuation of coverages during a period of layoff for which the Company would otherwise contribute the full cost of coverages under this subsection (b).

(4) The months of continuation as determined herein are subject to adjustment under the "Regeneration" provisions of Article III, Section 3(b).

(c) Unless otherwise specifically provided herein, the Company shall pay all expenses incurred by it in the administration of the Program.

Section 3. Company Options

(a) The options afforded the Company to provide coverages supplementary to state plan benefits or to substitute private coverages for state plan benefits as provided in Article I, Sections 3(a) and (b), respectively, of the Program shall be exercised only by mutual agreement between the Company and the Union.

(b) The options afforded the Company to provide coverages supplementary to any Federal coverages or to substitute coverages for the coverages provided by the Federal laws as provided in Article I, Sections 4(a) and (b), respectively, of the Program shall be exercised only by mutual agreement between the Company and the Union.

(c) The options afforded the Company to provide or withdraw coverages, to select carriers, or to change any other terms or conditions as provided for in the Program shall be exercised only by mutual agreement between the Company and the Union.

(d) If, in any locality a carrier fails to provide health care coverages set forth in the Program in reasonable conformance with the Program provisions, by mutual agreement between the Company and the Union, supplementary or replacement coverages shall be provided through another carrier.

Section 4. Administration

(a) Under Article I, 2(b) of the Program, the Company shall have the responsibility for administration

of the Program. The parties have agreed that the last sentence of Article I, 2(b)(1) will not apply to UAW-represented primary enrollees (and their related secondary enrollees). For such individuals, Program determinations may be reviewed under the “Process for Voluntary Review of Denied Claims.”

(b) The carrier(s) annually shall furnish the Company and the Union such information and data as may be mutually agreed upon by the parties with respect to coverages provided under the Program. A list of the agreed upon information and data to be furnished will be set forth in administrative manuals for the Program or under other arrangements mutually agreeable to the Company and the Union. When reasonable and practicable to differentiate it, such information and data shall be union-specific.

(c) Any provisions for coordination of benefits which may be established pursuant to Article I, Section 7 of the Program shall be implemented by mutual agreement between the Company and the Union.

(d) A Committee composed of an equal number of members designated by the Union and an equal number of members designated by the Company has been established to study and evaluate the health care coverages provided under the Program and to engage in activities that may have high potential for cost savings while achieving the maximum coverage and service for the Program enrollees for the money spent for such coverages. In the performance of its duties, this Committee shall consult with representatives of the Control Plan, carriers through which the health care coverages are administered, and others and keep the parties to the Collective Bargaining Agreement informed with respect to the problems which arise in the operation of such coverages.

Section 5. Coverages During Union Leave of Absence

(a) An employee who is on leave of absence requested by a local union to permit the employee to work for the local union may continue all health care coverages provided under the Program until the date such leave or any extension thereof ceases to be operative.

The employee shall contribute the full monthly cost of such coverages.

(b) Furthermore, such leaves of absence existing on the applicable effective date of the amended Program for any such employees will not operate to defer the effective dates of any such coverages for such employees under the Program.

Section 6. Coverages Following Loss of Seniority

(a) The provisions of Article III, Section 7 shall apply to an employee who loses seniority under the Collective Bargaining Agreement pursuant to Paragraphs (64)(a), (64)(b), (64)(c), (64)(d), (111)(a), or (111)(b), and all coverages provided under the Program shall cease as of the last day of the month in which seniority is lost.

(b) If an employee loses seniority pursuant to Paragraphs (64)(a), (64)(b), (64)(c), (64)(d), (111)(a), or (111)(b) of the Collective Bargaining Agreement, and if such employee is seeking to have the seniority reinstated through the grievance procedure established therein, all health care coverages provided under the Program may be continued while the grievance is pending beyond the period specified in (a) above. The employee shall contribute the full monthly cost for

health care coverages continued hereunder during the period of continuance beyond the period specified in (a) above.

Section 7. Active Service

For the purposes of determining eligibility and continuation rights under this Program, employees in “active service” as defined in Article IV, Section 1, shall include:

(a) local union representatives receiving compensation from the Company under Paragraphs (21) and (22) of the Collective Bargaining Agreement;

(b) employees whose absences are excused in advance and who are receiving compensation from the Company under Paragraphs (218), (218a), and (218b) of the Collective Bargaining Agreement (relating to jury duty, short-term military duty, and bereavement, respectively);

(c) employees on approved vacation time off under the applicable provisions of the Collective Bargaining Agreement;

(d) employees who would otherwise be scheduled to be at work and are absent due to a specified holiday and receiving compensation from the Company under Paragraph (203) of the Collective Bargaining Agreement;

(e) employees placed on Protected Employee status, pursuant to the Collective Bargaining Agreement; and

(f) employees on Paid Educational Leave (PEL) under the National PEL Program.

Section 8. Non-Applicability of Collective Bargaining Agreement Grievance Procedure

No matter respecting the Program as modified and supplemented by this Agreement, or any difference arising thereunder, shall be subject to the grievance procedure established in the Collective Bargaining Agreement. The parties have an established “Process for Voluntary Review of Denied Claims” (see Miscellaneous Health Care Program Documents). It replaces the procedure set forth in Article I, subsections 6, (c) and (e) of the Program.

Section 9. No Health Care in Retirement. Post-Retirement Program Coverages Inapplicable to Retirees or Retirees’ Surviving Spouses and Dependents.

In accordance with the 2009 UAW Retiree Settlement Agreement, nothing in this Program, shall be interpreted to entitle employees represented by the UAW or their respective spouses or dependents to participation upon retirement in this or any other plan or program covering medical benefits or health care in retirement.

Section 10. Duration of Agreement

This Agreement and Program as modified and supplemented by this Agreement shall continue in effect until the termination of the Collective Bargaining Agreement of which this is a part.

In witness hereof, the parties hereto have caused this Agreement to be executed the day and year first above written.

**INTERNATIONAL
UNION, UAW**

GARY JONES
TERRY DITTES
MIKE STONE
BRYAN CZAPE
MICHAEL GLENNING
DAVE SHOEMAKER
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MARK ZAYDEL

EXHIBIT C-1
THE GENERAL MOTORS
HEALTH CARE PROGRAM
FOR
HOURLY EMPLOYEES

ARTICLE I

ESTABLISHMENT, FINANCING AND ADMINISTRATION OF THE HEALTH CARE PROGRAM

Section 1. Establishment and Effective Date of the Program

(a) Establishment of the Program

General Motors LLC (the “Company”) will establish a Health Care Program for Hourly Employees, hereinafter referred to as the Program or this Program, either through a self-insured plan or by arrangement with a carrier or carriers as set forth herein.

(b) Effective Date of the Amended Program

The Program shall become effective as to each participating group as determined by the Company on October 28, 2019, except as otherwise provided herein. Until October 28, 2019, the provisions of the 2015 Program shall remain in effect unless expressly indicated otherwise.

Section 2. Company Costs and Administrative Items

(a) Net Costs

(1) The Company, or a trust, shall pay the balance of the net cost of the Program over and above any enrollee contributions or payments specified in the Program. The Company, or a trust, shall receive and retain any credits, refunds, or reimbursements under whatever name, arising out of the Program.

(2) The Company, by payment of claims through carriers administering the Program or by payment of its contributions, shall be relieved of any further liability with respect to the coverage(s) or benefit(s) provided under the Program, except as otherwise may be required by the Employee Retirement Income Security Act of 1974, as amended.

(b) Administration

(1) The Company is the Plan Administrator and has discretionary authority to interpret the terms of the Program and to determine eligibility for and entitlement to Program benefits in accordance with the terms of the Program. Any interpretation or determination made pursuant to such authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

(2) Except as agreed to between the Company and carriers, all administrative expenses incurred by the Company to execute the Program shall be borne by the Company.

(c) Grievance Procedure Not Applicable

It is understood that the grievance procedure of any collective bargaining agreement between the parties hereto shall not apply to this Program or any contract in connection therewith.

(d) Miscellaneous Information Related to the Employee Retirement Income Security Act of 1974 (ERISA)

(1) The end of the plan year is December 31. Records of the Program are kept on a calendar year basis.

(2) The Company is the sponsoring employer and Administrator of the Program. The Administrator's address is Mail Code 482-C32-A68, 300 Renaissance Center, Detroit, Michigan 48265- 3000.

(3) Service of legal process on the Company may be made at any office of the CT Corporation. The CT Corporation, which maintains offices in all 50 states, is the statutory agent for service of legal process on the Company. The procedure for making such service generally is known to practicing attorneys.

Service of legal process also may be made upon the Company, at the Service of Process Office, GM Legal Staff, 400 Renaissance Center, Mail Code 482- C38-210, Detroit, Michigan, 48265-4000.

(e) Assignment or Alienation of An Enrollee's Interests

Except as expressly authorized by this Program or as required to comply with a Qualified Medical Child Support Order under the Omnibus Budget Reconciliation Act of 1993, benefits, claims, coverage or other interests in the Program may not be assigned, transferred or alienated by an enrollee. With the approval of the Company however, a carrier may pay a provider directly for services rendered, in lieu of payment to an enrollee.

Section 3. Program in States With Disability Benefits Laws

(a) Not Applicable in States With Laws Providing Such Benefits

(1) The provisions of this Program shall not be applicable to employees in states having laws which now or hereafter may provide health care coverages, under whatever name, for employees who are disabled by non-occupational sickness or accident, or similar disability; and compliance by the Company with such laws shall be deemed full compliance with the provisions of the Program with respect to employees in such states. If such benefits exceed the benefits provided under the Program, the Company may require from employees in such states such contributions as it may deem appropriate for such excess benefits.

(2) In any state where the benefits under such state laws are on a generally lower level than the corresponding benefits under the Program, the Company shall, to the extent it finds it practicable, provide benefits supplementary to the state plan benefits to the extent necessary to make the total benefits as nearly comparable as practicable to the benefits of the plan provided by the Program in states without such laws.

(b) Substitution of Applicable Provisions of the Program for State Plan

The provisions of subsection (a) above to the contrary notwithstanding, the Company may, in any state wherein the substitution of a private plan is authorized by the law of such state, modify the provisions of the Program to the extent and in the respects necessary to secure the approval of the appropriate state governing body to substitute the plan provided by the Program in lieu of any plan provided by state law, and upon such modification and approval as a qualified plan, the Company may make the plan provided by the Program available to its employees in such state or states with such employee contributions as may be appropriate with

respect to any benefits under such modified plan which exceed the benefits provided under the Program.

Section 4. Federal Health Care Benefits

- (a) Not Applicable to Enrollees Eligible for Such Benefits

The provisions of the Program, separately or in combination, shall not be applicable to enrollees who are or may become eligible for health care benefits under any Federal health security act or any other law providing such benefits for the public at large which may be amended or enacted. Compliance by the Company with such laws shall be deemed full compliance with the provisions of the Program with respect to enrollees eligible for benefits under such laws. If such benefits exceed the benefits provided under the Program and the Company's contributions for such benefits under the Program, the Company may require from such enrollees such contributions as it may deem appropriate for such excess benefits.

If, as a result of such laws, the level of benefits provided for any group of enrollees is generally lower than the corresponding level of benefits under the Program, the Company may, at its option and to the extent it finds it practicable, provide a plan of benefits supplementary to the Federal benefits to the extent necessary to make total benefits as nearly comparable as practicable to the benefits provided under the Program.

- (b) Substitution of Applicable Provisions of the Program for Benefits Under Federal Laws

The provisions of subsection (a) above to the contrary notwithstanding, the Company may, if Federal

laws permit, substitute a plan of benefits for the benefits provided by the Federal laws referred to in subsection (a) above, and modify the provisions of the Program to the extent and in the respects necessary to secure the approval of such substitution from the appropriate governmental authority and may make such plan available to enrollees.

(c) Reduction of Health Care Benefits Because of Benefits Under Federal Law

Health care benefits, separately or in combination, provided enrollees under the Program may be reduced by the amount of such benefits provided under any Federal health security act or any other law which may be amended or enacted. In cases where the enrollee exercises an option under the Federal Social Security Act or similar law to take cash payments in lieu of health care benefits, the equivalent of such payments will be required as a contribution toward the health care coverages provided under the Program, but not to exceed the cost to the Company of such coverages. Such contributions may be deducted, in accordance with any applicable Federal laws, from any monies then payable to the enrollee in the form of wages or benefits payable under any General Motors benefit plan or program.

Section 5. Treatment of Existing Coverages on Effective Date

(a) Protection of employees currently covered under the Program shall be terminated on the effective dates of the provisions of the amended Program as to employees working on such effective dates, and the benefits provided by the Program shall be in lieu of and substitute for any and all other plans and benefits thereunder providing for health care benefits of any kind or nature, in which the Company participates.

(b) All employees currently covered under the Program who are not eligible to become covered on the effective date of the Program, as amended, or to whom any provision of the Program, as amended, is not applicable, shall be covered in accordance with the conditions, provisions, and limitations of the Program as constituted on the date each such employee was last actively at work as if such Program were being continued during the existence of the Program set forth herein.

Section 6. Named Fiduciary

(a) Except as set forth below, the Investment Funds Committee of the Company's Board of Managers shall be the Named Fiduciary with respect to the Program. The Investment Funds Committee may delegate authority to carry out such of its responsibilities as it deems proper to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended. General Motors Investment Management Corporation (GMIMCO) is the Named Fiduciary of the Program for purposes of investment of Program assets. GMIMCO may delegate authority to carry out such of its responsibilities as it deems proper to the extent permitted by The Employee Retirement Income Security Act of 1974.

(b) A mandatory appeal procedure has been established for review of denials of eligibility and/or of claims for benefits under the Program. The primary enrollee will be given adequate notice by the carrier, in writing, of the specific reasons for the denial, will be referred to the Program provisions on which the denial is based and an explanation of additional information required from, or on behalf of the enrollee for reconsideration of the claim. The primary enrollee will be given an opportunity for a full and fair review

by the Named Fiduciary, or its delegate, of the decision denying the claim. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the enrollee will be provided either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the enrollee upon request. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the enrollee will be provided either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the enrollee's medical circumstances, or a statement that such explanation will be provided free of charge upon request. For purposes of deciding appeals, the carrier responsible for administering the coverage, or responsible for administering Program eligibility, as applicable, is the delegate of the Named Fiduciary. Such delegates have discretionary authority to interpret and apply the Program on behalf of the Company. The individual or individuals at the carrier who decide the appeal will not be the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The review will not afford deference to the initial adverse benefit determination. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the carrier shall:

(1) consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(2) provide for the identification of medical or vocational experts whose advice was obtained on behalf of the carrier in connection with the primary enrollee's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and,

(3) provide that the health care professional engaged for purposes of the consultation referenced above shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

After the primary enrollee receives notice that a claim was denied, in whole or in part, the enrollee has at least 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, the enrollee may submit any written comments that may support the claim. A written decision on the request for review will be furnished to the primary enrollee as follows:

Urgent Care Claims - In the case of a claim involving urgent care, as defined by applicable regulations, the carrier shall notify the primary enrollee 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 the primary enrollee's 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 the primary enrollee 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 of the primary enrollee's 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 the primary enrollee's 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 the primary enrollee of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt by the carrier of the primary enrollee's 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 the primary enrollee's 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, the primary enrollee may initiate an action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

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

(1) Waives any right to assert that a primary enrollee has failed to exhaust administrative remedies because the primary enrollee 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.

(d) If a claim for benefits under the TCN option has not been approved on the basis that the Control Plan has determined that a service, supply, device or drug therapy is research, experimental or investigational in nature, the primary enrollee may request a review by an independent panel of three physicians who are recognized experts in the specialty at issue. In the event that such a review is conducted, the panel participants will be selected by parties independent of the Company and the carrier. At the Program's expense, the panel will review the case and, applying the standard of generally accepted medical practice, will determine whether the service, supply, device or drug therapy is research, investigational or experimental in nature as defined under the Program in the individual case under appeal. The panel shall have discretionary authority to interpret and apply the Program in making such determination. If at least two of the three physicians on the panel concur on a decision, that shall be the determination of the panel. The panel's decision shall be the final determination under the voluntary review process of the

Program for the case under review and shall be binding on the enrollee and the Company. The panel's decision shall not be considered as precedent for any other case.

(e) If the primary enrollee believes a decision of the Plan Administrator in the voluntary review process is inconsistent with the terms of the Program, a request for additional review may be filed with the Employee Benefit Plans Committee of the Company which has the final review authority under the voluntary review process with respect to the Program.

Section 7. Coordination of Benefits (COB)

(a) General Provisions

Health care benefits paid under this Program shall not duplicate benefits from other sources (e.g., group plans, comprehensive plans, pre-paid plans, governmental plans, etc.), nor serve to relieve other persons or organizations of their liability (contractual or otherwise). Consistent with these objectives, the Company may establish systems and procedures for coordination of benefits, and the carriers shall implement such systems and procedures.

(b) Applicability

(1) The provisions of this Section shall apply to all coverages provided under the Program. Unless precluded by law, these provisions apply whether the coverage is self-funded, or provided through pre-paid options such as health maintenance organizations.

(2) This Program shall not coordinate with individual or family policies of insurance purchased by the enrollee or with any group policy covering the enrollee for which the enrollee pays more than one half the cost.

(3) The provisions of this Section shall not apply to expenses for services provided to or for an enrollee in relation to any condition, disease, illness or injury arising out of or in the course of employment, as such expenses are specifically excluded from the Program.

(4) The provisions of this Section shall not apply to Federal or State Medicare or Medicaid. However, they do apply to complementary coverage carried to supplement benefits available under such Federal or State programs and to other employers' plans or programs which may be primary to Medicare by virtue of Federal law.

(c) Enrollee Obligations

(1) Primary enrollees shall furnish to the Company the social security numbers of all secondary enrollees for whom they are claiming eligibility and for whom they are required to provide a social security number to claim an exemption on the primary enrollee's Federal income tax return. If the secondary enrollee has not been assigned a social security number at the time of enrollment, a social security number shall be obtained promptly and reported to the Company. Failure to do so shall result in cancellation of coverages for such secondary enrollee.

(2) Any enrollee claiming benefits under this Program shall furnish the Program or the carrier(s) any information necessary for the purpose of administering these provisions.

(d) Release of Information

(1) The Program or carriers may release to other plans or carriers information necessary to adjudicate claims under these provisions, as permitted by applicable regulations.

(2) The Program, or carriers under this Program, may participate in organizations which are established to facilitate the COB process and may exchange information relating to enrollees for such purposes.

Such organizations must agree not to release any information obtained other than for the purpose of effectuating COB.

(e) Determining Priority

(1) The program which, under the rules of this subsection, has the first obligation to pay benefits is termed the “primary” program, and the coverages it provides are “primary.” The other program (and the coverages it provides) is termed “secondary.”

(2) When the other program does not contain a COB provision, that program is always primary.

(3) When the other program contains a COB provision and the order of benefit determination under both programs’ COB provisions establish this Program as primary, the provisions of this Program determine this Program’s liability, regardless of any payment the other program may have made.

(4) When the other program contains a COB provision, the following order of benefit determination will be used.

(i) The program covering the enrollee as an employee will be primary over the program covering the enrollee as a dependent.

(ii) When the enrollee is a dependent child whose parents are not divorced or separated, the program covering the enrollee as a dependent of the

parent whose birthday occurs earlier in the calendar year will be primary over the program covering the enrollee as a dependent of the parent whose birthday occurs later in the calendar year. If the two parents' birthdays fall on the same day, the program which has covered the parent for the longer period of time will be primary.

(iii) When the enrollee is a dependent child whose parents are divorced or separated, and if there is a court order establishing financial responsibility with respect to health care expenses of the child, the program which covers the child as a dependent of the parent with such responsibility shall be primary.

If there is no court order, and the parent having custody of the child has not remarried, the program covering the child as a dependent of the parent with custody shall be primary. If there is no court order and if the parent having custody has remarried, the program covering the child as a dependent of the parent having custody shall be primary, any program covering the child as a dependent of the stepparent shall be secondary, and the program covering the child as a dependent of the parent without custody shall determine its liability last.

(iv) When rules (i), (ii), and (iii) above do not establish an order of benefit determination, the program which has covered the enrollee for the longer period of time will be primary. However, if one program covers the enrollee as an active employee (or dependent of such employee) and the other covers the enrollee as a laid-off or retired employee (or dependent of such employee), the program covering the enrollee as an active employee (or dependent of such employee) shall be primary. Also, if the other program does not have a provision regarding laid-off or retired employees, and as a result both programs take a secondary position under their respective rules, the provisions of this subsection

(iv) shall not apply and the rules of the other program shall determine which program is primary.

(f) Payment of Benefits

(1) If this Program is primary, a carrier may reimburse a secondary program for any amounts paid by such program which should have been provided by this Program.

(2) If benefits under this Program are overpaid by a carrier for any claim involving COB, the carrier shall have the right to recover such overpayment from the hospital, physician, or other provider of service, from the other program, or from the primary enrollee, as appropriate. Alternatively, the Company may recover on its own behalf, under Section 9 below.

(3) With regard to any claim for which this Program has secondary liability, benefits provided under this Program shall not exceed the amount of benefits payable if this Program had been primary.

(4) "Benefits paid or payable" under another program include the benefits that would have been payable had a claim been made under the primary program, or which would have been payable by the primary program but for the enrollee's failure to comply with the provisions of such program. When a program provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be a benefit payable by such program.

(5) When this Program is secondary,

(i) sanctions provided under this Program (e.g., for failure to obtain predetermination, for failure

to obtain a required second opinion, for failure to obtain services from a panel provider, etc.) will not apply,

(ii) payment will be made only to the level which would have been paid by this Program had it been primary, and

(iii) no payment will be made for services which are not covered under this Program.

Section 8. Reimbursement for Third Party Liability

(a) If health care benefits are paid to, or on behalf of, an enrollee and if the enrollee makes recovery from a third party, individual or organization for any covered expenses for which benefits were paid, the Program shall be entitled to reimbursement in an amount equal to the benefits paid to, or on behalf of, the enrollee under this Program. This shall not apply to policies of insurance issued to and in the name of such enrollee. Carriers administering the Program shall take such actions as may be necessary to preserve or assert such right of reimbursement on the Program's behalf.

(b) The enrollee shall perform such acts and shall execute and deliver to the Company or the carrier such instruments and papers as may be necessary to secure such rights of reimbursement.

Section 9. Recovery of Benefit Overpayments

If it is determined that any benefit(s) paid to, or on behalf of, an enrollee under this Program should not have been paid or should have been paid in a lesser amount, written notice thereof shall be given to the

applicable primary enrollee and such primary enrollee shall repay the amount of the overpayment.

If the primary enrollee fails to repay such amount of overpayment promptly, the Company shall arrange to recover the amount of such overpayment by making an appropriate deduction or deductions from any monies then payable, or which may become payable, by the Company or on the Company's behalf, or otherwise, to the primary enrollee in the form of wages or benefits. The Company shall have the right, in accordance with applicable Federal laws, to make, or to arrange to have made, deductions for recovering such overpayments from any such present or future wages or benefits which are or become payable to such employee.

Section 10. Compliance with Federal Laws

Notwithstanding any provisions of the Program to the contrary, the Company shall modify administration, coverages and other terms and conditions of the Program, as necessary, to comply with applicable federal laws and regulations.

Section 11. Protected Health Information (PHI)

(a) The Company will comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules for use and disclosure of PHI, effective April 14, 2003. The Company will also take such actions as may be necessary for continued compliance, in the event of subsequent amendment to HIPAA and/or implementation of related federal regulations.

(b) Permitted uses and disclosures of PHI by the Company in its Plan Sponsor capacity are limited to those associated with sponsorship of the Program.

(c) The Program may release PHI to the Company in its Plan Sponsor capacity, so long as the Plan Sponsor certifies to:

(1) Not use or further disclose the PHI other than as permitted or required by subsection (b) above or as required by law;

(2) Require any agents, including a subcontractor, to whom it provides PHI, to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) In the absence of an appropriate authorization, not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company, except that use or disclosure in connection with workers compensation matters will be allowed as permitted by HIPAA;

(4) Agree to report to the Program any use or disclosure of PHI that is inconsistent with the uses or disclosures provided by subsection (b) above, if and when the Plan Sponsor becomes aware of such inconsistent use or disclosure;

(5) Authorize the Program to make PHI available to enrollees as required by law;

(6) Authorize the Program to make PHI available to enrollees for amendment and to incorporate any such amendments as required by law;

(7) Authorize the Program to make available to enrollees an accounting of disclosures of PHI as required by law;

(8) Agree to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Program available to the Secretary of the Department of Health and Human Services for purposes of determining the Program's compliance with HIPAA; and

(9) If feasible, return or destroy all PHI received from the Program and which is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction infeasible.

(d) The Program establishes adequate separations from the Plan Sponsor as described in (1), (2) and (3) below.

(1) The Company designates specific people, the Plans Workforce, who may use and disclose PHI on behalf of the Program for purposes of plan administration functions. The Plans Workforce interacts with certain Business Associates to perform these functions. Plan administration includes, but is not limited to, eligibility determinations, claims processing, precertification or preauthorization, billing, coordination of benefits, subrogation, business management, customer service, enrollment, audit functions, fraud and abuse detection, quality assurance and disease management. Plan administration does not include any employment-related functions or functions in connection with any other benefits or benefit plans, and the Program may not disclose PHI for such purposes absent an authorization from an individual

to whom the information pertains, except that use or disclosure in connection with workers compensation matters will be allowed as permitted by HIPAA.

(2) Access and use of PHI by Plans Workforce members is limited to plan administration functions performed on behalf of the Program.

(3) Any issues of non-compliance by Plans Workforce members will be investigated. For General Motors employees, non-compliance may result in disciplinary action up to and including termination of employment. In the case of contract workers or consultants, non-compliance may result in termination of the contract.

(e) The Program may use and disclose PHI as described in (1), (2), (3) and (4) below.

(1) The Program may disclose PHI to the Company in its capacity as Plan Administrator, to carry out plan administration functions consistent with subsection (d).

(2) The Program may disclose PHI to the Plan Sponsor only if an applicable notice of privacy practices with a provision permitting such disclosure has been provided to enrollees.

(3) In the absence of an appropriate authorization, the Program may not disclose PHI to the Company for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company, except that use or disclosure in connection with workers compensation matters will be allowed as permitted by HIPAA.

(4) Access to PHI is restricted to persons who need it to carry out their job duties in administering the Program. Use and disclosure is limited to the amount reasonably necessary to accomplish the intended purpose.

(f) The Program may disclose Summary Health Information to the Company in its Plan Sponsor capacity for the purpose of:

(1) Obtaining premium bids from health plans for providing coverage under the Program; or

(2) Modifying, amending, or terminating the Program.

ARTICLE II

HEALTH CARE COVERAGES

Section 1. Establishment of Health Care Coverages

(a) Core Coverages

The Company shall continue its arrangements to make core coverages (hospital, surgical, medical, prescription drug, and hearing aid coverages as set forth in Appendix A and mental health and substance abuse coverages as set forth in Appendix B) available. Collectively, the coverages shall be known as the Informed Choice Plan.

(b) Non-Core Coverages

The Company shall continue its arrangements to make non-core coverages (dental and vision coverages as set forth in Appendices C and D, respectively, to this Program) available.

(c) Supplemental Plans

This Program may include certain supplemental plans which only are applicable according to their terms, including the GM Temporary Employee Health Care Plan (Appendix F), the GM Hourly Retiree Health Care Plan (Appendix G), and the GM Subsystems Manufacturing LLC Health Care Plan (Appendix H).

Section 2. Uniform National Health Care Coverages

(a) The Company shall provide uniform health care coverages, nationwide, as described in this

Program and Appendices A, B, C, and D hereto, through arrangements with appropriate carriers.

(b) Core coverages (other than mental health and substance abuse) for enrollees shall be those provided under a national system by agreement between the Company and the medical plan carrier, hereinafter referred to as the Control Plan, or by agreement with other carriers where applicable.

(c) The Control Plan shall have responsibility for assuring that the core coverages as defined in Appendix A are provided and administered uniformly for Traditional Care Network option enrollees.

All carriers agreeing to provide such coverages under the Program, shall do so in accordance with interpretations and benefit practices established by the Control Plan.

(d) Under the national system each carrier with a written agreement with the Control Plan will provide uniform core coverages, as described in Appendix A, in the carrier's respective geographic area. If in any geographic area a carrier fails to enter into the agreement as stated above, or fails to perform in accordance with its agreement, the Control Plan, with the approval of the Company, shall provide such health care coverages in the geographic area or arrange with another carrier to do so.

(e) Core and non-core coverages may be provided through the Health Maintenance Organization option. However, the coverages provided through this option may vary from the coverages described in Appendices A and B.

Section 3. Replacement or Supplementation of Coverages

If in its judgment the Company considers it advisable in the interest of the enrollees in any geographic area, another arrangement may be substituted in such area or areas for all or part of the coverages referred to in Section 1 above.

Section 4. Selection of Option in the Informed Choice Plan

The Company will make arrangements to provide an opportunity for primary enrollees to elect to have core coverages provided through one of the options available under the Informed Choice Plan. Such election also may include a choice among dental options, where applicable. The specific choices offered to a primary enrollee will depend on the availability of approved options in the enrollee's geographic area and Medicare status of the primary and secondary enrollees. The options are as follows:

(a) Health Maintenance Organization (HMO) Option

This option provides coverages to enrollees through physicians, hospitals, and other providers who have agreed to provide services under the terms established by the health maintenance organization to limit fees, assure quality, and control utilization.

(1) The types of coverages and the scope and level of coverages provided under this option may vary among health maintenance organizations and may be different than the coverages set forth in Appendices A and B.

(2) Most health maintenance organizations provide health care coverages (including preventive care) that generally are managed for the enrollee by a primary care physician. The primary care physician is responsible for referring the patient to other providers of service. If such referral is not obtained, the enrollee may be responsible for charges incurred.

(3) Under this option, if an enrollee receives services from a non-health maintenance organization provider, in a non-emergency situation or without a referral, such services may not be covered.

(4) The Company pays a premium or capitated fee to health maintenance organizations for enrollees electing coverage through this option. The fee paid is based upon a comparison of the monthly rates of the health maintenance organization and those of the base option in the rating area. When the health maintenance organization's rates are higher than those of the base option, the enrollee may be required to make a contribution.

(b) Traditional Care Network (TCN) (Preferred Provider Organization (PPO)) Option

The TCN option provides core coverages, as described in Appendix A, generally through access to a PPO network of providers offered within a defined service area. Such network providers have agreed to provide services under the terms of participation established by the TCN carrier, such as limits on fees, and controls on quality and utilization. In areas where there is a TCN network, in order to receive full benefits for certain covered services, such services must be obtained through the TCN's network of providers.

(1) The TCN option may include predetermination and review procedures required in order to receive full benefits for certain covered services. These procedures include but are not limited to predetermination (which includes, but is not limited to, prior authorization or assessment for non-emergency inpatient admissions), concurrent utilization review, retrospective utilization review, and focused utilization review. In some instances, special programs (such as predetermination of specific outpatient procedures) will be developed and implemented, as necessary and practicable, to address specific utilization problems.

(2) Benefits for certain covered services, which require predetermination, when provided without obtaining necessary predetermination approvals will be administered according to Program standards including the provision that such services be payable at 80% of reasonable and customary charges after the first \$100 of expense 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%.

Under this subsection, the 80% payment limitation and the requirement that payment be made for the first \$100 of covered expenses shall not be applicable (i) to an individual enrollee who has incurred a personal expense of \$750 under this provision for such covered services in a calendar year or (ii) to the covered members of the enrollee's family, if any, after the enrollee and such members have incurred a total of \$1,500 in personal expense under this provision for such covered services in the same calendar year.

(3) The carriers assume responsibility for conducting utilization reviews, predetermination of services, or other reviews necessary to promote quality of care and control costs. The carriers may place the panel physician at financial risk through capitation, withholding of a percentage of fees, or other mechanisms, or if not, will have other means to monitor and control utilization by individual providers on a continuous basis.

(4) The carriers assume responsibility for selection and periodic evaluation of hospitals, physicians, laboratories, and other providers to create a network of sufficient numbers and types of providers who are geographically distributed to allow adequate access for enrollees within a service area as defined by the carrier.

(5) The carriers assume responsibility for making available the scope and level of benefits set forth in Appendix A, monitoring the appropriateness of referrals to non-panel providers, taking corrective action with regard to network providers who do not meet their contractual network obligations, and implementing and maintaining other administrative processes as required by the Company.

(6) Office visits by enrollees to network providers, or to other providers with an approved advance referral, are subject to a \$25 co-payment per visit.

(i) Office visits to non-network providers, without an approved advance referral, are not covered and are the enrollee's responsibility.

(ii) The provisions of Article II, 4(b)(9) below, are not applicable to office visit coverage.

(7) Urgent Care Center (UCC) visits are subject to a \$50 co-payment for each visit to a network UCC for covered services.

(i) For covered services obtained at a non-network UCC, the enrollee is responsible for the network UCC co-payment plus possible additional amounts in excess of the network allowed amount. The carrier's payment to a non-network UCC will be the network allowed amount for the same service, or if less the actual charges, minus the network UCC co-payment.

(ii) The UCC co-payment will be waived if the enrollee is transferred directly from the UCC to an Emergency Room. In this situation, the provisions under Article II, 4(b)(8) below will then apply.

(iii) The provisions of Article II, 4(b)(9) below, are not applicable to UCC coverage.

(8) Emergency Room (ER) visits are subject to a \$100 co-payment for each visit to an ER to receive covered services related to an accidental injury as defined in Appendix A.1.A. or a medical emergency as defined in Appendix A.1.N.

(i) The ER co-payment will be waived if the enrollee is admitted into the hospital directly from the emergency room or placed into observation to receive covered services.

(ii) If the enrollee receives covered ER services at a non-network provider and does not have the ability or control to select a network provider, the carrier will defend the enrollee on the basis that the allowed amount is the reasonable and customary reimbursement for the services or supplies in question. In such situations, the enrollee is still responsible for ER co-payment.

(iii) The provisions of Article II, 4(b)(9) below, are not applicable to ER coverage.

(9) Unless the enrollee is referred by a network provider and receives approval for the referral prior to receiving services from a non-network provider, payment for covered services provided by non-network providers, will be 90% of the network allowed amount for the same service or, if less, the actual charges.

(i) The 90% limitation on payment for services provided by non-network providers shall not be applicable in a situation in which, according to Program standards, the enrollee does not have the ability or control to select a network provider to perform the service. In such situations, if the provider attempts to collect an amount in excess of the allowed amount from the enrollee, the carrier will defend the enrollee on the basis that the allowed amount is the reasonable and customary reimbursement for the services or supplies in question.

(ii) The 90% limitation on payment for services provided by non-network providers shall not be applicable to an individual enrollee who has incurred personal expense under this provision of \$250 for such covered services in a calendar year.

(iii) The 90% limitation on payment for services provided by non-network providers to the covered members of the enrollee's family, if any, after the enrollee and such members have incurred a total of \$500 in personal expense under this provision for such covered services in the same calendar year.

(iv) With the exception of situations in which subsection 4(b)(9)(i), above, applies, amounts above the carrier allowed amount are the responsibility of

the enrollee. Such amounts do not count toward the maximums in subsections 4(b)(9)(ii) and (iii), above, and enrollee responsibility for the excess amounts continues to apply after maximums are reached.

(10) Primary and secondary enrollees eligible for Medicare may not be subject to the predetermination and review procedures set forth above for those covered services for which Medicare has primary responsibility.

(11) Non-emergency mental health and substance abuse inpatient services provided by non-panel providers without referral by a panel provider are also subject to the non-panel payment limitations and included in the out-of-pocket maximums described above.

(12) Telehealth visits are subject to a co-payment equal to half of the office visit co-payment for each visit to an approved telehealth provider for covered services.

(i) Telehealth visits with a non-preferred vendor or to a non-network provider are not covered and are the enrollee's responsibility.

(ii) The provisions of Article II, 4(b)(9) above, are not applicable to telehealth visit coverage.

(13) Retail health clinic visits are subject to a co-payment equal to half of the office visit co-payment for each visit to an in-network retail health clinic for covered services.

(i) Retail health clinic visits to a non-network provider are not covered and are the enrollee's responsibility.

(ii) The provisions of Article II, 4(b)(9) above, are not applicable to retail health clinic coverage.

ARTICLE III

ENROLLMENT, ELIGIBILITY, COMMENCEMENT, CONTRIBUTIONS AND CONTINUATION

Section 1. Enrollment

(a) A primary enrollee must complete an application for the coverages in which the enrollee elects to participate. The application or enrollment form shall include an authorization for payroll or pension deductions for contributions which may be required.

(1) At the primary enrollee's option such coverage may include protection for (i) self only (single), (ii) self and spouse or self and child (two-party), or (iii) self and two (2) or more dependents (family). Family coverage shall include only spouse and eligible children as defined in Section 9 of this Article.

(2) The primary enrollee may elect (i) core coverages alone, (ii) core coverages plus any or all non-core coverages, (iii) any or all non-core coverages without core coverages or (iv) waive all coverages. The primary enrollee's election determines coverage for all dependents.

(3) When multiple options exist as to carrier (e.g., TCN and HMOs) the primary enrollee's election also shall apply to all dependents.

(4) When a husband and wife both qualify as primary enrollees, each may make a separate election. However, no individual may have coverage as both a primary and a secondary enrollee, nor as a secondary enrollee under more than one primary enrollee.

(5) If a primary enrollee's coverage otherwise available under this Program is waived or canceled, and based upon such waiver or cancellation the primary enrollee receives some financial consideration under any other Company plan or program, such primary enrollee shall be precluded from coverage as a secondary enrollee under another person's coverage, for a period of time equal to that upon which such consideration is based. This provision also applies to secondary enrollees, if any, included in the waiver or cancellation on which such consideration is based.

(b) The primary enrollee may be required to make monthly contributions as set forth in the Program, according to the enrollment classification, carrier option, marital status, and type and number of dependents enrolled.

Section 2. Dates of Eligibility, Commencement of Coverages, and Company Contributions for Active Employees

(a) Eligibility and Commencement of Coverages for Present and New Employees

An employee, including In-Progression employees, shall automatically become covered for all health care coverages on January 1, 1988 or if later, on the 91st calendar day of employment. Employees who have met the above requirement but who are not in active service on the effective date as established above will have coverage activated immediately upon return to work. However, for purposes of this subsection 2(a), if an employee is scheduled to be at work, but is absent due to disability, and is consequently placed on a disability leave of absence, the employee will be deemed to be in active service and at work.

(b) Eligibility and Commencement of Coverages for Employees Changing Employment Location

The provisions of subsection 2(a) above shall not apply to an employee who loses seniority due to a quit from a location where the employee has health care coverages in force to become or remain employed at a second location. In such case, health care coverages shall be terminated at the first location as of the end of the month in which the employee loses seniority, and shall become effective at the second location on the following day, provided the employee is on the active employment roll at such second location on the date of such loss of seniority at the first location.

(c) Eligibility and Commencement of Coverages for Employees Returning to Active Work

If an employee's coverages are discontinued and the employee subsequently returns to active work, eligibility for coverages shall be determined under subsections (a) and (b) above, except as provided in subsections (1) through (4) below. For purposes of this subsection 2(c), if an employee is scheduled to return to work, but is unable to do so because of disability, and is consequently placed on a disability leave of absence, the employee will be deemed to have returned to work effective with the date the employee would otherwise have returned to work, but for the disability leave.

(1) Returning From Layoff or Leave of Absence

If an employee's coverages were discontinued while on layoff or leave of absence and the employee returns to active work with seniority, the employee shall be eligible for reinstatement of all health care coverages immediately on the date of return to active work with the Company.

**(2) Returning From Separation From Service
Due to a Quit or Discharge**

If separation from service was due to a quit or discharge but the employee is reemployed within 31 days, the employee shall be eligible for reinstatement of all health care coverages immediately on the date of return to active work.

**(3) Returning From Separation From Service for
Reason Other Than Quit or Discharge**

If separation from service was due to a reason other than quit or discharge and the employee had health care coverages in effect before seniority was canceled, and if the employee returns to active work within a period of 24 consecutive months, the employee shall be eligible for all health care coverages immediately on the date of return to active work with the Company.

(4) Returning From Military Leaves of Absence

An employee reporting for work from military leave of absence in accordance with the terms of such leave shall be eligible for reinstatement of all health care coverages as of the date the employee reports available for work.

**(d) Company Contributions for Employees in
Active Service**

(1) With respect to any month in which the employee is in active service with the Company and eligible for coverage as specified in this Section 2 as of the beginning of the month, the Company shall make contributions for that month's coverages as specified in the Program.

(2) With respect to any month in which an employee does not meet the requirements of subsection 2(d)(1) above by virtue of not being in active service at the beginning of the month, but in which an employee returns to work and is eligible for reinstatement of coverages under subsection 2(c) above, the Company shall make contributions as specified in the Program effective with the date of return to work.

Section 3. Continuation of Coverages During Layoff

(a) The Company shall make contributions, as provided under Section 2 above, so that all health care coverages will be provided until the end of the month in which the employee is last in active service.

(b) Coverages shall be continued during periods of layoff for up to 25 consecutive months (except as provided in the following paragraph) following the last month of coverage for which the Company contributed for the employee in accordance with subsection (a) above, provided the employee's seniority is not broken.

Notwithstanding any other provisions of this Section 3 if an employee is on permanent layoff and returns to active work with the Company and is subsequently laid off prior to the day next following the 12th pay period for which the employee has earnings from one or more Company plants within a calendar year, the number of months for which coverage may be continued as of the first day of the month next following the month in which the employee last works, and the number of months for which the Company shall contribute for any such continued coverage, shall be equal to the number of such months, respectively, which were available as of the last day of the month immediately preceding the

date of return to work with the Company following the permanent layoff increased by two additional months.

(c) The Company has established a schedule on the basis of Seniority, or on some other basis, under which the Company will contribute, during a specified number of full calendar months of layoff, for coverages continued in accordance with subsection (b) above.

(d) **Employees Placed On Layoff From Disability Leave of Absence**

If an employee reports for work from an approved disability leave of absence and is immediately placed on layoff, the day the employee reports for work shall be deemed to be the last day in active service prior to layoff for purposes of this Section. The coverages to be continued during such layoff will be those for which the employee was covered on the actual day last worked.

(e) **Employees Placed On Layoff From Military Leave of Absence**

If an employee reports for work from military leave of absence in accordance with the terms of such leave and is immediately placed on layoff, the day the employee reports for work shall be deemed to be the last day worked prior to layoff but only for purposes of determining the period of continuation and eligibility for Company contributions for such coverages under the provisions of the Program applicable to laid-off employees.

(f) Employees Placed on Layoff Who Opt Out of the Transition Support Program

If an employee elects to opt out of the Transition Support Program, the employee will continue to receive coverages for the remaining number of months of continuation in accordance with subsection 3(b) above.

Section 4. Continuation of Coverages During Disability Leave of Absence

(a) Health care coverages shall be continued for the duration of an approved disability leave of absence provided the employee is totally and continuously disabled.

(b) If an employee's disability leave is canceled because the period of such leave equaled the length of the employee's seniority, coverages continued while on disability leave, in accordance with subsection (a) above, shall continue to remain in force in any month in which the employee continues to receive Sickness and Accident Benefits or Extended Disability Benefits in accordance with the General Motors Life and Disability Benefits Program for Hourly Employees subsequent to such cancellation.

For In-Progression employees, at the end of the month in which the maximum Sickness and Accident Benefits or Extended Disability Benefits amount is payable, the employee's coverage for health care will cease.

(c) An employee who becomes disabled and would be eligible for total and permanent disability benefits under any Company pension plan or retirement program then in effect but for the fact of not having the years of credited service required to be eligible for such benefits, may elect to terminate seniority with the Company in order to become eligible for certain benefits under other

Company benefit plans or programs. If such an employee is age 65 or older at the time seniority is terminated, Section 6 of this Article shall apply. If such an employee is less than age 65 at the time seniority is terminated, the employee may continue coverages on a self-paid basis for a period equal to the employee's seniority on the last day worked. Continuation of coverages under this subsection (c) is conditioned upon the submission of such periodic proof of the continuance of such disability as the Company may reasonably require.

(d) Notwithstanding any other provisions of this Section 4, if an employee is on permanent layoff and returns to active work with the Company and subsequently becomes disabled prior to the day next following the 12th pay period for which the employee has earnings from one or more Company plants within a calendar year, the number of months for which coverage may be continued as of the first day of the month next following the month in which the employee last works, and the number of months for which the Company shall contribute for any continued coverage, shall be equal to the number of such months, respectively, which were available as of the last day of the month immediately preceding the date of return to work with the Company following the permanent layoff increased by two additional months.

(e) Notwithstanding any other provisions of this Section 4, if an employee on disability leave of absence is determined to be "Able" in accordance with the Impartial Medical Opinion Program of the General Motors Life and Disability Benefits Program for Hourly Employees, and does not return to work following such determination, health care coverages will be discontinued on the first day of second month following the month in which such determination is made and not reinstated until the employee returns to work.

(f) The Company shall make contributions, in accordance with Program provisions, for health care coverages continued in accordance with subsections (a) and (b) above.

(g) Employees shall contribute the full cost for health care coverages continued in accordance with subsection (c) above.

Section 5. Continuation of Coverages During Other Leaves of Absence

(a) All health care coverages for an employee on an approved leave of absence other than for disability shall be continued to the end of the month in which the employee is last in active service.

(b) An employee who desires to continue coverages beyond the period specified in subsection (a) above may do so, on self-paid basis, under the provisions of applicable federal law, but in no event for a period of less than twelve (12) months.

(c) If an employee has not broken seniority and has continued coverages as provided in subsection (b) above during an approved leave of absence other than for disability, granted because of a clinically anticipated disability based on the natural course of the employee's diagnosed condition, and presents medical certification from the employee's personal physician, satisfactory to the Company, that the employee is totally disabled, health care coverages shall be provided, as of the date such certification is presented, on the same basis as set forth in Section 4.

(d) The Company shall make contributions for health care coverages continued in accordance with subsection (c) above, on the same basis as set forth in Section 4, as of the date certification of disability is presented.

Section 6. Continuation of Coverages Upon Retirement or Termination of Employment at Age 65 or Older

(a) The health care coverages an employee has at the time of retirement or termination of employment at age 65 or older (for any reason other than a discharge for cause) with insufficient credited service to entitle the employee to a benefit under Article II of The General Motors Hourly-Rate Employees Pension Plan may be continued.

(b) An employee who upon retirement is not enrolled for the coverages as provided in subsection (a) above may enroll for health care coverages to which entitled at the time of or subsequent to retirement. Such coverage shall become effective on the first of the month following receipt of application from such retired employee.

(c) Except as provided in subsection (d), below, the Company shall make contributions, in accordance with Program provisions, for health care coverages continued in accordance with subsections (a) and (b) above, for:

(1) a retired employee (including any eligible dependents), provided such retired employee is eligible for benefits under Article II of The General Motors Hourly-Rate Employees Pension Plan; and

(2) an employee (including any eligible dependents) terminating at age 65 or older (for any reason other than a discharge for cause) with insufficient credited service to be entitled to a benefit under Article II of The General Motors Hourly-Rate Employees Pension Plan.

(d) Company contributions will not be made for employees hired on or after November 18, 1996 who, at the time of retirement or termination at age 65 or older, have fewer than ten (10) years of credited service under the Company's Pension Plans. Such individuals may elect to continue coverage on a self-paid basis.

(e) The provisions of this Section 6 are inapplicable to In-Progression employees. The opportunity for survivors of these employees to continue coverage post-employment or for periods not in active service will be limited to self-paid continuation that may be available under federal law.

Section 7. Continuation of Coverages Upon Termination of Employment Other Than by Retirement or Death

(a) Except as provided in Article III, Section 4(c) above, health care coverages for an employee who quits or is discharged shall automatically cease as of the last day of the month in which the employee quits or is discharged or, if later, the date seniority is broken.

(b) Following termination of employment other than by retirement or death, the former employee shall be entitled to self-paid continuation of coverages provided under applicable federal laws, and/or may be offered a conversion contract.

Section 8. Continuation of Coverages for the Survivors of an Employee, or of a Retired Employee or Certain Former Employee

(a) If an employee dies prior to becoming eligible for health care coverages under Section 2 above, the Company shall permit the spouse of such employee to

participate in the core coverages, on a self-pay basis, as provided in subsection (b)(1) below.

(b) If an employee or retiree dies after coverages are in effect under the Program, coverage for any dependents will cease as of the end of the month in which the employee or retiree dies. Thereafter, a surviving spouse may be eligible to continue coverages as indicated below.

For purposes of this Section 8 and of Article V, “surviving spouse” does not include the spouse of a former employee eligible for a deferred pension under Article VII, Section 2 of The General Motors Hourly Rate Employees Pension Plan; or a spouse or former spouse receiving, or eligible to receive, a pre-retirement survivor benefit under Article II, Section 11 of the previously referenced Pension Plan.

(1) The Company shall make suitable arrangements for the surviving spouse of an employee to participate, on a self-pay basis, in core coverages for the first 24 months following the month in which the employee dies, provided the surviving spouse was married to the deceased employee for at least one full year immediately preceding the date of death.

(2) The Company shall make contributions for core coverages continued in accordance with subsection (b)(1) above, for the first twelve months following the month in which the employee dies, provided that, as of the employee’s date of death, the surviving spouse’s age is at least 45, or the surviving spouse’s age, when added to the deceased employee’s seniority, totals 55 or more.

Thereafter, the surviving spouse may continue core coverages, on a self-pay basis, until the earlier of (a) remarriage, (b) the end of the month in which age 62 is attained, or (c) death.

(3) The Company shall make suitable arrangements for a surviving spouse

(i) of an employee or retired employee (but not the surviving spouse of a former employee eligible for a deferred pension or a surviving spouse or surviving divorced spouse eligible for a pre-retirement survivor benefit under Article II, Section 11 of The General Motors Hourly Rate Employees Pension Plan) if such spouse is receiving or is eligible to receive a survivor benefit under Article II of The General Motors Hourly Rate Employees Pension Plan,

(ii) of a retired employee if, prior to death, the retired employee was receiving a benefit under Article II of The General Motors Hourly-Rate Employees Pension Plan,

(iii) of a former employee whose employment was terminated at age 65 or older for any reason other than a discharge for cause with insufficient credited service to be entitled to a benefit under Article II of The General Motors Hourly-Rate Employees Pension Plan, or

(iv) of an employee who at the time of death was eligible to retire on an early or normal pension under Article II of The General Motors Hourly-Rate Employees Pension Plan, to participate in health care coverages; provided, however, that dental coverage shall be available to a surviving spouse age 65 or over only for months that such surviving spouse is enrolled for Medicare Part B coverage.

(4) The Company shall make contributions for health care coverages continued in accordance with subsection (b)(3) above only on behalf of a surviving spouse, as provided therein and in subsection (b)(5) below (including for this purpose a surviving spouse who would receive survivor benefits under The General Motors Hourly-Rate Employees Pension Plan

except for receipt of Survivor Income Benefits under the General Motors Life and Disability Benefits Program), and the eligible dependents of any such spouse; provided, however, that the contributions on behalf of a surviving spouse for the month the surviving spouse becomes age 65 and subsequent months shall be made only for months that the surviving spouse is enrolled for Medicare Part B coverage.

Notwithstanding the above, no Company contributions, other than contributions related to subsection (b)(5) below, shall be made under this subsection (b)(4) for the surviving spouse and eligible dependents of a deceased employee or retiree hired on or after November 18, 1996, if such employee or retiree had fewer than 10 years of credited service under the Company's Pension Plans.

(5) The Company shall make suitable arrangements for a surviving spouse of an employee whose loss of life results from accidental bodily injuries caused solely by employment with General Motors Company, and results solely from an accident in which the cause and result are unexpected and definite as to time and place, to participate in health care coverages; provided, however, such coverages shall terminate upon the remarriage or death of the surviving spouse. Any Company contributions for coverages continued under this subsection (b)(5) shall be as provided in subsection (b)(4) above.

(6) A surviving spouse who is eligible for such coverages provided in subsections (b)(1), (b)(3) and (b)(5) above and who elects such coverages but who is not eligible for Company contributions as provided in subsections (b)(2) and (b)(4), must make such election no later than 60 days following the later of the end of the month in which the death of the employee, retired employee, or former employee occurs, or following the

date of notice of available options by the Company, and shall contribute monthly the entire cost for such coverages for (i) single party, (ii) two party, or (iii) family.

(7) When contributions by surviving spouses are required, they shall be paid in cash directly to the Company or its agent on or before the 10th day of the month for which such coverages are to be provided or such other due date as may be established by the Company.

(c) The provisions of this Section 8 are inapplicable to In-Progression Employees. The opportunity for survivors of these employees to continue coverage post-employment or for periods not in active service will be limited to self-paid continuation that may be available under federal law.

Section 9. Dependent Eligibility Provisions

(a) General Provisions

(1) As used in this Section 9, when reference is made to a person (i.e. person A) being “dependent upon” another person (i.e. person B), the term shall mean that person B may legally claim an exemption for person A, under Section 151 of the Internal Revenue Code, for Federal income tax purposes.

(2) The provisions of this Section 9 apply with respect to enrollment of certain dependents as secondary enrollees under primary enrollees who elect “self and spouse,” “self and child,” or “self and family” enrollment, in accordance with Article III, Section 1(a)(1) of the Program. Unless specifically provided otherwise in the Program, such a dependent has no individual or personal right of enrollment, right to select an option within the Informed Choice Plan, or right to continue coverages under the Program.

(3) Company shall have the right of determining eligibility of a dependent, consistent with the provisions of this Program.

(4) A primary enrollee claiming initial or continuing eligibility of a dependent shall furnish whatever documentation may be necessary to substantiate the claimed eligibility of a dependent and the social security number of each such dependent for whom a social security number is required to claim an exemption on the primary enrollee's Federal income tax return. Refusal or failure to furnish such documentation when requested to do so, or to furnish the social security number within a reasonable period of time, shall result in denial or withdrawal of eligibility for such dependent.

(5) Unless otherwise provided, a dependent who loses eligibility in accordance with the provisions of this Program, and who once again meets the requirements for dependent eligibility, may have coverage reinstated. The effective date of coverage in such cases will be the first day of the month following the month in which a valid enrollment form and any necessary supporting documentation is received by the Company.

For purposes of establishing an effective date under this provision only, if the request for reinstatement of coverage is based on "full-time" student status as provided in Article III, 9(c)(1)(ii), proof of enrollment as a full-time student for one school term will be accepted subject to subsequent submission of proof that such school term was completed.

(6) When, as a result of oversight or error, an eligible primary or secondary enrollee entitled to Company-paid 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.

This retroactive enrollment provision shall not apply to surviving spouses who are not entitled to Company-paid coverage. Such surviving spouses electing to continue coverages on a self-paid basis must make such election as stipulated in Article III, Section 8(b)(6).

(7) The receipt of a benefit under The General Motors Hourly-Rate Employees Pension Plan as an “alternate payee” in accordance with the Retirement Equity Act of 1984 shall not serve to entitle such recipient to coverages or continuation of coverages under this Program.

(8) Provisions will be made for the enrollment and administration of coverage for an individual determined to qualify for coverage pursuant to Qualified Medical Child Support Orders (QMCSO) under the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA ‘93).

(b) Spouse

(1) The spouse of an eligible and enrolled employee shall be eligible for coverage. A surviving spouse of an employee, as defined in Section 8 above, may not have or add a new spouse as a dependent.

(2) A spouse by common-law marriage shall be eligible for coverage only to the extent such relationship is recognized by the laws of the state in which the employee is enrolled, and the employee has met such requirements for documentation of the status as may be necessary by law and required by the Company.

(3) The effective date of coverage for a spouse shall be the later of the effective date of coverage for the employee, or the date of marriage. For a common-law spouse, the effective date of coverage shall be the date of receipt by the Company of a completed enrollment form and any necessary supporting documentation.

(4) A spouse's eligibility for coverage shall cease on the earlier of:

(i) the date the primary enrollee's coverage ceases, except that, in the case of the primary enrollee's death, coverage shall cease on the last day of the month in which the primary enrollee dies, unless the spouse is eligible for coverage as a surviving spouse as set forth in Section 8 of this Article, or

(ii) the date of the final decree of divorce.

(c) Children

(1) Children of a primary enrollee, or of the spouse of an eligible and enrolled employee, shall be eligible for coverage if, as to each one, the following criteria are met.

(i) Relationship. The child must be the child of the primary enrollee, or of an employee's spouse, by birth, or legal adoption, or legal guardianship.

For purposes of this subsection, effective September 26, 2007, children by "legal guardianship" will be limited to children who are related by blood to the primary enrollee or the primary enrollee's current spouse.

Under the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), a child under the age of 18 who is in the process of being adopted by an employee will be deemed to satisfy the relationship

test when the child is placed and takes up residence with the employee, pursuant to the adoption process.

This requirement will be deemed to have been met for a child who was properly enrolled under the then applicable Program's "guardianship" provisions as of September 26, 2007, who has continued to be the primary enrollee's dependent since that time, and who has been continuously enrolled and has continuously satisfied the other eligibility criteria for children.

(ii) Age. The child must not have reached the end of the calendar year in which the child becomes age 19, unless such child has been determined to be totally and permanently disabled or is a full-time student, as indicated below.

For the purposes of this subsection, "totally and permanently disabled" means having any medically determinable physical or mental condition which prevents the child from engaging in substantial gainful activity and which can be expected to result in death or be of long-continued or indefinite duration.

Coverage will not be reinstated for a child who first becomes totally and permanently disabled after the end of the calendar year in which age 19 is attained or who was eligible for coverage as a totally and permanently disabled child, recovers, and, after the end of such calendar year, again becomes so disabled.

Effective January 1, 2009, a child who has reached the end of the calendar year in which such child turns age 19, has not reached the end of the calendar year in which such child turns age 24, and has not been identified as totally and permanently disabled, will satisfy this age requirement only if such child is a full-time student for at least one school term during

the calendar year. Coverage may be continued while the child continues to maintain such full-time student status, but in no event beyond the end of the calendar year in which such child turns age 24.

(iii) Marital Status. The child must be unmarried.

(iv) Residency. The child must reside with the primary enrollee, as a member of such enrollee's household or, if not a member of the household, such enrollee must be legally responsible for the provision of health care for the child (such as children of certain divorced parents, legal guardianships, children confined in training institutions, or children in school)

(2) An eligible surviving spouse may not enroll a child unless the child was eligible to be enrolled prior to the death of the employee or, in the case of a child born after the death of the employee unless such child is the issue of the surviving spouse's marriage to the deceased employee, and was conceived prior to such employee's death.

(3) The effective date of coverage for a child shall be the later of the effective date of coverage for the primary enrollee, or in the case of:

(i) Birth - the date of birth;

(ii) Legal Adoption - the date the adoption becomes final in accordance with applicable laws (or, for children being adopted and who meet the criteria of OBRA '93, the date the child is placed and resides with the adopting employee);

(iii) Legal Guardianship - the date guardianship becomes final in accordance with applicable laws; and

(iv) Stepchild - the date the child becomes a member of the employee's household

(4) A child, as defined above, shall cease to be eligible for coverage as of:

(i) the date of marriage of such child;

(ii) the last day of the month in which the child ceases to meet the residency criteria of subsection (c)(1)(iv) above;

(iii) the last day of the calendar year in which the child becomes age 19, except in the following cases:

Totally and Permanently Disabled Children. Coverage may be provided/continued for calendar years beyond age 19 for an otherwise eligible child who becomes totally and permanently disabled prior to the end of the calendar year in which the child turns age 19. In addition, coverage may be continued for calendar years beyond age 19 for a child eligible and enrolled in coverage that becomes totally and permanently disabled after the child turns age 19 but prior to the end of the calendar year in which the child turns age 24. Eligibility shall cease as of the last day of the month in which the child ceases to be totally and permanently disabled as defined by this Program.

Full-time Students Who Have Not Reached the End of the Calendar Year in Which They Turn Age 24. Coverage may be provided/continued for calendar years beyond age 19 (but not beyond the end of the calendar year in which age 24 is attained) for a child who is a full-time student; however, eligibility shall cease as of the last day of the month in which the primary enrollee reasonably should know the child will not maintain such status for at least one school term during the calendar year; or

(iv) the date the primary enrollee's coverage ceases, except that, in the case of the primary enrollee's death, coverage for such dependent child shall cease on the last day of the month in which the primary enrollee dies, unless such child is eligible for coverage as a dependent child of the surviving spouse of such employee.

(5) Notwithstanding any other provisions of the Program, the Program shall provide coverages in accordance with Section 4301 of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) and Section 609 of ERISA. The Company will maintain reasonable procedures related to the implementation of Qualified Medical Child Support Order and other aspects of the Federal regulations.

(6) Pursuant to the Patient Protection and Affordable Care Act, effective January 1, 2011, children by birth or legal adoption of a primary enrollee, or the spouse of a primary enrollee, do not have to meet the age, marital status, and residency criteria described in subsection (c)(1) above, in order to be eligible for coverage through the end of the month in which the child turns age 26. Should this law be appealed or amended to no longer require this extension of eligibility for the children by birth or legal adoption of a primary enrollee, or the spouse of a primary enrollee, the age, marital status, and residency requirements will again be required in order for the child to be eligible for coverage.

Section 10. Conversion Privilege

(a) Any former enrollee who is no longer eligible to continue coverages under the Program, may be offered an opportunity to obtain other available coverage, on a self-paid basis, from the carrier with whom enrolled at the time eligibility terminated.

(b) A former enrollee wishing to exercise this privilege shall make application to the carrier within thirty (30) days of termination of eligibility under this Program.

Section 11. Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, or the Act), as amended, provides continuation rights to certain employees or dependents who would ordinarily lose eligibility for coverage under the Program.

If amendments to the Act or the applicable regulations preclude administration in accordance with the following provisions, the Company will make any changes necessary to comply with COBRA.

(a) For purposes of COBRA, this Program is considered to be a single plan offering “core coverages” (hospital, surgical, medical, prescription drug, hearing aid, mental health and substance abuse) and “non-core coverages” (dental and vision), regardless of the carrier option (TCN, HMO, etc.) chosen by the primary enrollee, or of the entity chosen by the Company to administer such coverages on the Company’s behalf.

(b) The Company is responsible for providing notifications, as required under COBRA, to “qualified beneficiaries,” as defined therein. The Company may delegate the administrative functions associated with COBRA.

(c) To the extent the Company makes alternative continuation privileges available under Article III of the Program that do not satisfy all the requirements for “COBRA continuation coverage,” enrollees shall have the opportunity to elect either the COBRA continuation coverage or continuation under the Program. An election of COBRA continuation coverage will terminate the enrollee’s eligibility for Program continuation.

(d) To the extent the Company makes alternative continuation privileges available under Article III of the Program that do satisfy all of the requirements for “COBRA continuation coverage,” such alternative continuation privileges will be integrated with the COBRA continuation coverage.

(e) In the event a primary enrollee is entitled to elect between COBRA continuation coverage and alternative continuation provided under the Program, coverage will be continued beyond the point coverage as an active employee or dependent of an active employee ceases as if the primary enrollee elected alternative continuation under the Program. If the primary enrollee subsequently elects COBRA continuation during the election period and pays any required contribution, coverages will be adjusted retroactively to provide the COBRA continuation.

(f) Unless advised otherwise by a COBRA “qualified beneficiary,” an election of alternative continuation by the primary enrollee shall be presumed to be an election for all other enrollees and/or qualified beneficiaries covered under such primary enrollee’s coverage.

ARTICLE IV

DEFINITIONS

Unless otherwise indicated, as used in this Program:

1. “active service” or “in active service” means receiving pay for regular hours of work scheduled by the Company, or otherwise scheduled to work but absent due to either,

(a) vacation time off authorized in advance,

(b) a specified holiday, or

(c) bereavement, jury duty, or short-term military leave of absence under circumstances where the absence is authorized in advance and the employee is entitled to receive full or partial compensation from the Company for the day(s) of absence.

An employee is not in active service if the employee is absent every scheduled work day during a month, for reasons other than those specified above, whether or not such absence is excused.

An employee is not in active service in any full month in which such employee is not scheduled to work due to layoff or any leave of absence (other than short-term military leave referred to in subsection (c) above), regardless of whether the employee may be entitled to some compensation for any day(s) during such month.

2. “allowed amount” (also sometimes referred to as “reasonable and customary amount”) – as it relates to covered expenses, unless otherwise specified, generally means any of the forms and amount of payment made by carriers to reimburse panel, network, participating,

or otherwise contracted providers for the services in question, or, if less, the provider's actual charges for the services. In some cases, the carrier may be called upon to defend an enrollee from the effort of a non-panel/-network/-participating/-contracted provider to collect an amount in excess of the allowed amount. In doing so, the carrier may take into consideration, among other factors:

(a) the usual amount the individual provider most frequently charges the majority of patients or customers for a similar service rendered or materials furnished;

(b) 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; and

(c) unusual circumstances or complications requiring additional time, skill or experience with the particular service rendered or materials furnished.

The carrier is responsible for determining the appropriate allowed amount for a given provider and service or material, and such determination shall be conclusive.

3. "*benefit*" - means a payment made, in accordance with the Program provisions, to an enrollee, or to a provider on behalf of an enrollee.

4. "*carrier*" means any entity by which Program coverages are administered or benefits are paid.

5. "*cost of coverages*" - means the Company's reasonable estimate of the monthly amount required to provide coverages for an individual or group of individuals, established on an actuarial basis taking into

account such factors as type of coverages (one-party, two-party, or family), form of delivery (TCN, HMO, etc.), scope of coverages (what services are covered), regional cost differences, administrative costs, etc. It includes both the Company contribution and any primary enrollee contribution(s), as required under the Program. The cost is accrued and reported on a monthly basis.

In the case of coverages delivered through certain pre-payment agencies, such as a health maintenance organization, it means the total monthly premium required to provide such coverages.

6. As used in this Program, the various forms of covered expense that an enrollee may be responsible for paying are as follows:

(a) *“Monthly contribution”* means an amount an enrollee may be required to pay, on a monthly basis, for health care coverage. The amount may vary, depending on option elected (e.g., TCN, or HMO). When a monthly contribution is required, either a “single” or a “family” contribution will apply.

(b) *“Annual deductible”* means an aggregate amount an enrollee may be responsible for paying each calendar year for covered services prior to the Program making a payment. “Single” and “family” deductibles may apply. Once the deductible is met, co-insurance may apply.

(c) *“Co-insurance”* means an amount an enrollee may be required to pay to a provider for covered services or supplies, once any applicable deductible(s) is (are) met. Such amount is calculated as a percentage of the approved amount for the services or supplies. The co-insurance percentage may vary, depending on

whether or not the services are obtained from network or panel providers.

(d) “*Co-payment*” means a fixed-dollar amount that an enrollee may be required to pay to a provider for specific covered services or supplies (such as emergency room visits and/or prescription drugs) at the time the service or supply is provided. Enrollees are responsible for any required co-payments, regardless of the status of deductibles or out-of-pocket maximums (if applicable).

(e) “*Annual out-of-pocket maximum*” means a maximum aggregate dollar amount an enrollee may be required to pay during a given calendar year for the deductibles and co-insurance amounts charged for certain covered services. Separate “in-network” and “out-of-network” out-of-pocket maximums may apply, depending on whether or not the covered services are performed by TCN network or panel providers, as applicable.

(f) “*Sanction*” - means an amount of otherwise covered expense that an enrollee incurs for failure to follow Program provisions (such as the sanction an employee may incur for failure to complete a substance abuse treatment plan).

7. “*coverage*” - means a specified set of health care services or expenses (i.e., “covered services or expenses”) which may be incurred by an enrollee, and for which benefits may be paid under the Program provisions. The categories of coverage include “core” coverages (hospital, surgical, medical, hearing aid, prescription drug, mental health and substance abuse) and “non-core” coverages (dental and vision). Not every health care expense incurred by an enrollee falls within the Program coverages.

8. “*covered service*” - means a service that is included within the range of services identified in the Program, and that meets all Program requirements for payment of benefits. A service within the range of those identified in the Program (e.g., a diagnostic radiology service) but which does not meet all of the specifications for a benefit payment (e.g., if it is an experimental service or if it is not medically necessary) is considered a non covered service.

9. “*effective date*” - means the date on which a given coverage begins for an enrollee, as determined by the employer, consistent with the Program provisions.

10. “*employee*” –

(a) means any person regularly employed on an hourly-rate basis in the United States by the Company or by a wholly-owned or substantially wholly-owned domestic subsidiary thereof, which the Company Board of Managers or its designee for such purposes has approved for inclusion and as specifically identified in Appendix E to this Plan, herein referred to as hourly persons or hourly employees, including:

(1) hourly persons employed on a full-time basis;

(2) hourly persons employed on incentive pay plans;

(3) students from educational institutions who are enrolled in cooperative training courses on hourly rate;

(4) part-time hourly employees who, on a regular and continuing basis, perform jobs having definitely established working hours, but the complete

performance of which requires fewer hours of work than the regular work week, provided the services of such employees are normally available for at least half of the employing unit's regular work week; and

(b) The term "employee" shall not include:

(1) employees represented by a labor organization which has not signed an agreement making the Program applicable to such employees;

(2) employees of any directly or indirectly wholly-owned or substantially wholly-owned subsidiary of the Company except as their participation in this Plan is expressly approved by the GM Board of Managers;

(3) "*leased employees*" as defined under Section 414(n) of the Internal Revenue Code; or

(4) contract employees, bundled services employees, consultants, or other similarly situated individuals, or individuals who have represented themselves to be independent contractors.

The following classes of individuals are ineligible to participate in this Program, regardless of any other Program terms to the contrary, and regardless of whether the individual is a common-law employee of the Company:

(i) Any individual who provides services to the Company where there is an agreement with a separate company under which the services are provided. Such individuals are commonly referred to by the Company as "contract employees" or "bundled services" employees;

(ii) Any individual who has signed an independent contractor agreement, consulting agreement, or other similar personal service contract with the Company;

(iii) Any individual who both (a) is not included in any represented bargaining unit and (b) the Company classifies as an independent contractor, consultant contract employee, or bundled-services employee during the period the individual is so classified by the Company.

The purpose of this provision is to exclude from participation all persons who may actually be common-law employees of the Company, but who are not paid as though they were employees of the Company, regardless of the reason they are excluded from the payroll, and regardless of whether that exclusion is correct.

(c) To the extent a labor organization has signed an agreement with the Company, and under such agreement certain employees represented by such labor organization are excluded from the Program in whole or in part, such represented employees shall be regarded as employees for the purposes of this Program only to the extent required to comply with such agreement.

11. “*employer*” - means the Company.

12. “*enrollee*” - means a person who is eligible for coverages under the Program and who is enrolled for such coverages. Depending upon the context, an enrollee may be a “primary enrollee” or a “secondary enrollee”. The determination of eligibility in a manner consistent with the Program provisions is the responsibility of the employer

“primary enrollee” - means employees, retirees or surviving spouses eligible in their own right.

“secondary enrollee” - means a spouse, or child entitled to coverage on account of a primary enrollee.

13. *“layoff”* - means any layoff resulting from a reduction in force or temporary layoff, or from the discontinuance of a plant or operation, or a layoff occurring or continuing because the employee was unable to do the work offered by the Company although able to perform other work in the plant to which the employee would have been entitled if such employee would have had sufficient seniority.

14. *“Medicare”* - means the Federal program established by Title XVIII of Public Law 89 97, as amended, which provides health insurance for the aged and disabled. It includes Part A (Hospital Insurance Benefit for the Aged and Disabled) and Part B (Supplementary Medical Insurance Benefit for the Aged and Disabled).

15. *“Plan”* - means the “Informed Choice Plan”, or that portion of the Program providing hospital surgical, medical, prescription drug, hearing aid, mental health and substance abuse coverages.

16. *“Plan Sponsor”* - means General Motors Company in its capacity of sponsoring the Program by engaging in activities including, but not limited to, establishment, maintenance, modification, and funding of the Program.

17. *“Plans Workforce”* – means employees, contract workers, and/or consultants performing plan administration functions employed or engaged by the Health Care Staff; the Health Care Finance Staff; the

GM Benefits and Services Center; the Chief Privacy Officer; members of the Employee Benefit Plans Committee; assigned members of the GM Audit Staff while performing Program audits; and assigned members of the Personnel and Labor Relations Practice Area of the GM Legal Staff who advise the Program.

18. “*Protected Health Information*” – as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), means information created or received by a health plan, health care provider, or health care clearinghouse that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual. In addition, the information either identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

19. “*provider*” means a person or entity which furnishes covered services or supplies to an enrollee.

20. “*seniority*” means whichever of the following periods is applicable to the employee.

(a) If the employee is represented under a collective bargaining agreement, seniority for the purposes of this Program shall be the same as seniority is defined in such Agreement. However, if the employee has, or has had, seniority in more than one bargaining unit under a collective bargaining agreement, “seniority” shall mean the longest seniority held in any bargaining unit. If an employee has seniority in one bargaining unit (or is in active service and subsequently acquires seniority in such bargaining unit) at the time the employee’s seniority is broken in a second bargaining unit

(1) under the time-for-time provisions of the collective bargaining agreement,

(2) because of a refusal of recall to such second bargaining unit,

(3) because of a quit at such second bargaining unit to respond to recall at another bargaining unit, or

(4) because of a quit at such second bargaining unit to accept placement as a journeyman/woman in another bargaining unit where the employee completed apprentice training, the seniority lost at such second bargaining unit shall be included in the “longest seniority.”

(b) If the employee is non-represented, seniority for the purposes of this Program shall be unbroken service as defined by rules established by the Company.

(c) Solely for the purposes of this Program, if an employee retired under the terms of The General Motors Hourly-Rate Employees Pension Plan is rehired, but does not have seniority reinstated, the employee shall be deemed to have seniority while so employed.

21. “*Summary Health Information*” – means information that may be individually identifiable health information, and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan, and which has been de-identified, except that the geographic information need only be aggregated to the level of a five-digit zip code, if such aggregation does not identify an individual.

APPENDIX A

**HOSPITAL, SURGICAL, MEDICAL,
PRESCRIPTION DRUG AND HEARING AID
COVERAGES
(THE INFORMED CHOICE PLAN)**

I. Definitions

As used herein:

A. “*accidental injury*” means a bodily injury such as a strain, sprain, abrasion, contusion or other condition which occurs as the result of a traumatic incident such as, but not limited to: ingestion of poison; overdose of medication, whether accidental or intentional; allergic reaction resulting from trauma, such as bee stings or insect bites; inhalation of smoke, carbon monoxide, or fumes; burns, frostbite, sunburn, and sunstroke; and attempted suicide.

B. “*actual OPEB trend rate*” means a percentage figure determined by comparing the two 12-month periods from January 1 to December 31 preceding August 1 of each year (e.g., at August 1, 2006, the Actual OPEB Trend Rate applicable to 2007 will be a percentage figure determined by comparing 2005 calendar year actual experience to 2004 calendar year actual experience. The Actual OPEB Trend Rate will be based on the actual aggregate incurred claims for enrollees covered under the Program for the most recent calendar year preceding the August 1 of each year, divided by the actuarially expected incurred claims for the same calendar year using the prior year’s actual claims costs, less 1.0, and converted to a percentage. Actuarially expected incurred claims for the same calendar year using prior year’s actual claim costs will be calculated by multiplying the demographic census for the

current year by the actuarially determined, age based, per capita incurred claims costs (in conformance with Financial Accounting Standard 106) for the prior year.

Actual incurred claims experience is measured using at least 15 months of paid claims data for the incurred calendar year plus an actuarially developed estimate for final actual claims payment run-out. Claims experience represents the aggregate claims for medical, prescription drug, and vision benefits. For this purpose, actual aggregate incurred claims for the calendar year shall reflect the effect of any increases in dollar-denominated plan design items, which increase annually as of the beginning of each calendar year, for that year. Adjustment in actuarially expected claims associated with plan design changes shall be made in a manner consistent with the methodology used to recognize plan design changes under Financial Accounting Standard 106.

C. “*ambulance services*” means medically necessary transportation and life support services furnished within the Program provisions to sick, injured or incapacitated patients by a licensed ambulance provider meeting Program standards, utilizing ambulance vehicles and personnel recognized as qualified to perform such services at the time and place where rendered.

D. “*benefit period*” means a period of time during which an enrollee is entitled to receive certain covered services which are subject to Program maximums. These include, but are not limited to, inpatient hospital services (with special provisions for pulmonary tuberculosis treatment under this Appendix, and mental health and substance abuse treatment under Appendix B), admissions to skilled nursing facilities (whether under this Appendix or Appendix B), treatment under psychiatric and substance abuse day care or

night care programs, and substance abuse halfway house programs under Appendix B, hospice care and utilization of home health care services (see App. A, II.B. and App. B, II.B.).

E. “*covered expenses*” means the allowed amount for covered materials and services, as described in Section III of this Appendix and, 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 this Program. Such covered expenses fall in the following areas of coverage or categories of expenses:

1. hospital expenses;
2. skilled nursing facility expenses;
3. physical, speech and functional occupational therapy expenses;
4. home health care expenses;
5. medical, surgical expenses;
6. ambulance service expenses;
7. prescription drug expenses;
8. hearing aid expenses;
9. durable medical equipment and prosthetic or orthotic appliance expenses; and
10. hospice expenses.

F. “*custodial*”, “*domiciliary*” or “*maintenance*” care or services means the type of care or service which, even if ordered by a physician, is primarily for the purpose of meeting personal needs of the patient or maintaining a level of function (as opposed to

specific medical, surgical, or psychiatric care or services designed to reduce the disability to the extent necessary to enable the patient to live without such medical care or services). Custodial, domiciliary or maintenance care can be provided by persons without special skill or training.

It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care and checking of routine vital signs.

G. “*drugs, biologicals, and solutions*” means medicinal agents which are approved for commercial distribution by the Federal Food and Drug Administration and are legally prescribed for the treatment of an illness or injury.

H. “*durable medical equipment*” means equipment which 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.

I. “*engineering method of rounding*” means the following rules of rounding numbers:

1. If the leftmost of the digits discarded is less than 5, the preceding digit is not affected. For example, when rounding to four digits, 130.646 becomes 130.6.

2. If the leftmost of the digits discarded is greater than 5, or is 5 followed by digits not all of which are zero, the preceding digit is increased by one. For example, when rounding to four digits, 130.557 becomes 130.6.

3. If the leftmost of the digits discarded is 5, followed by zeros, the preceding digit is increased by

one if it is odd and remains unchanged if it is even. The number is thus rounded in such a manner that the last digit retained is even. For example, when rounding to four digits, 130.5500 becomes 130.6 and 130.6500 becomes 130.6.

J. “*freestanding outpatient physical therapy facility*” means a facility, separate from a hospital, which provides outpatient physical therapy services. Such facilities must meet Program standards and be approved by the local carrier.

K. “*home health care agency*” means a centrally administered agency providing physician-directed nursing and other paramedical services to patients at home. A home health care agency must meet all Program standards and be approved by the local carrier.

L. “*hospice*” means a program of medical and non-medical services provided for terminally-ill enrollees and their families through agencies which administer and coordinate the services.

“pre-hospice” means 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.

Both pre-hospice services and the hospice program must meet Program standards and be approved by the local carrier.

M. “*hospital*” means a facility which, in return for compensation from its patients, provides diagnostic and therapeutic services on a continuous inpatient basis for the surgical, medical, or psychiatric diagnosis, treatment, and care of injured or acutely sick persons. These services are provided by, or under the supervision of, a

professional staff of licensed physicians and surgeons. A hospital continuously provides 24 hour-a-day nursing service by registered nurses. A rehabilitation institution shall be considered to be a hospital if the institution is approved as such under this Program. A hospital must meet all applicable local and state licensure and certification requirements and be accredited as a hospital by state or national medical or hospital authorities or associations.

A hospital is not, other than incidentally, a place for custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care; an institution for exceptional children; an institution to which enrollees may be remanded by the judicial system; an institution for the treatment of the aged or substance abusers; or a skilled nursing facility or other nursing care facility. It does not include a health resort, rest home, nursing home, convalescent home, or similar institution.

N. “*medical emergency*” means 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.

O. “*Non-Physician Practitioner*” means an individual who meets Program Standards for the given profession and is approved by the carrier for reimbursement for certain professional services in accordance with their training and licensure which would be covered under the Program when

performed by a physician. The carrier will assure that multiple practitioners will not be reimbursed for the same service. Program Standards for non-physician practitioners shall include, but not be limited to, the requirements that the individuals be registered, certified and/or licensed as applicable under state law, be legally entitled to practice their specialties at the time and place services are performed, that they render specified services which they are legally qualified to perform and that they be approved for Medicare reimbursement, if applicable, for enrollees who have Medicare as their primary coverage.

The categories of non-physician practitioners, and the services that may be covered when performed by them, include:

1. *“Advance Practice Nurses”* means health care professionals including, but not limited to, certified nurse practitioners, clinical nurse specialists, certified nurse mid-wives and certified nurse anesthetists. These health care professionals must be accredited by their respective national societies and endorsed through state licensing processes.

2. *“Audiologist”* means a health care professional who possesses a master’s or doctorate degree in audiology or speech pathology from an accredited university, possesses a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association, and meets state licensure requirements. Certain services of an audiologist may be covered under this appendix when performed in response to a medical diagnosis and when Program standards are met. In addition, services may also be covered under hearing aid coverage (see App A. III.H).

3. “*Physician Assistants*” means health care professionals licensed to practice medicine with physician supervision. Physician assistants must be accredited by the Accreditation Review Commission on Education for the Physician Assistant, certified by the National Commission on Certification of Physician Assistants and meet state licensure requirements.

P. “*orthotic appliance*” means an external device intended to correct any defect of form or function of the human body.

Q. “*participating provider*,” “*network provider*” or “*panel provider*” means any hospital, skilled nursing facility, outpatient physical therapy facility, home health care agency, physician, or other approved provider under this Program which, at the time an enrollee receives services, has entered into a contract or agreement with a carrier to provide health care services in accordance with such contract or agreement, including a provision that the provider accepts the allowed amount as determined by the carrier, as payment in full. A “participating provider” has agreed to a carrier contract under a traditional plan arrangement. A “network provider,” as used in this Program, has agreed to a carrier contract associated with a network of providers (usually a PPO network) offered within a defined service area and used to support the TCN option. A “panel provider,” as used in this Program, has agreed to a carrier contract associated with a PPO network offered in a defined service area. An individual provider may be any one or all of the above types of contracted providers (participating, network and/or panel) or may not contract with a carrier at all. A “non-participating” provider may act as a “participating provider” for individual claims in those areas where carriers allow “per case” participation.

R. “*physician*” means 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 which they are legally qualified to perform.

1. “*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 diseases of the teeth and related structures. Such services are provided for under the dental coverage (see App. C of the Program). However, certain services of a dentist may be covered under this Appendix when provided in accordance with App. A, III.E.3.a.(2), or when performed in response to a medical diagnosis and when Program standards are met. A dentist also may prescribe medications which may be covered under the prescription drug coverage (see App. A, III.G.).

2. “*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 or hands. Services of podiatrists, relating to the feet or hands, may be covered under the surgical and medical coverages (see App. A, III.E.). A podiatrist also may prescribe medications which may be covered under the prescription drug coverage (see App. A, III.G.).

3. “*chiropractor*” means a doctor of chiropractic (D.C.) whose scope of practice is the diagnosis and treatment of subluxations or misalignments of the spinal column and related bones and tissues which produce

nerve interference. Services of chiropractors which may be covered under this Appendix are limited to diagnostic radiological services (see App. A, III.E.3.l.), emergency first-aid (see App. A, III.E.3.h.), and outpatient physical therapy services (see App. A, III.C.3.a.) all pertaining to the spine and related bones and tissues.

Under this Program, a chiropractor may not prescribe medications, perform invasive procedures or incisive surgical procedures, nor perform physical examinations not related to the spine and related bones and tissues.

4. “*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 this Appendix when performed in response to a medical diagnosis and when Program standards are met. Services may also be covered under mental health and substance abuse coverage (see App. B of this Program).

S. “*private room*” means a room containing one bed.

T. “*Program standards*” means criteria established by the Control Plan (and approved by the Company) for approval of providers or for benefit payment. At a minimum, providers must meet applicable accreditation, licensing and credentialing requirements and be qualified to render services or furnish materials under this Program. In the case of provider approval, standards also may include, but are not necessarily limited to, such matters as approval for Medicare reimbursement, acceptance of Medicare assignment and/or Program reimbursement as payment in full. In the case of benefit payment, standards may include, but are not necessarily limited to, such matters as the

service or item being approved by Medicare and/or the service or item being delivered or prescribed in response to particular diagnoses. Local carriers shall be responsible for ensuring that local providers conform to such standards, or for obtaining approval of exceptions through the Control Plan.

U. “*prosthetic appliance*” means an artificial device which replaces an absent part of the body, or which aids the performance of a natural function of the body without replacing a missing part.

V. “*provider*” means a physician, hospital, or other approved facility, agency or individual who is qualified to render service(s) or furnish materials under this Program.

W. “*retail health clinic*” means a medical setting, sometimes referred to as a walk-in clinic, generally staffed by nurse practitioners, physician assistants, or physicians who provide treatment for uncomplicated minor illnesses and/or preventive health care services. Retail health clinics may be located inside of larger retail operations. A retail health clinic must meet Program standards, and be recognized and approved by the carrier as a retail health clinic.

X. “*semiprivate room*” means a room containing two beds.

Y. “*service*” means any care or procedure, as listed and limited herein, which is provided for diagnosis or treatment of disease, injury or pregnancy and which is based on valid medical need according to accepted standards of medical practice. Certain types of care or procedures may be excluded as covered services under this Program.

Z. “*skilled nursing facility*” means 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 Program standards and be approved by the local carrier.

AA. “*special care unit*” means a designated unit within a hospital (such as cardiac care, burn care, or intensive care unit) that concentrates all necessary types of equipment together with skilled nursing and supportive services needed for care of critically ill patients and is recognized as such by the carrier.

AB. “*telehealth*” means a resource, the purpose of which is to diagnose, treat, and prescribe medication as needed for common health issues through the use of electronic information and telecommunications technologies. A telehealth provider must meet Program standards and be approved by the carrier.

AC. “*urgent care center*” means a medical setting distinct from a hospital emergency room, the purpose of which is to diagnose and treat illness or injury for unscheduled, non-routine ambulatory patients seeking immediate medical attention for conditions that are not life threatening.

II. Terms and Conditions

A. Payment of Benefits

1. Benefits will be payable, subject to the provisions of this Program, when an enrollee incurs a covered expense.

2. Under the Program, benefits for certain covered services are payable only if “approved” by the carrier or preferred provider organization and/or if furnished by approved providers, when applicable. If such approval is not obtained, or if such providers are not utilized, any benefits for such services may be reduced or eliminated. Examples include, but are not limited to, TCN option enrollees’ failure to comply with the predetermination requirements for inpatient admissions, or Health Maintenance Organization option enrollees’ failure to utilize health maintenance organization providers as set forth in Article II, Section 4.

3. Benefits may be payable in full (up to the carrier’s allowed amount) for services rendered by non-network or non-panel providers if such services are rendered on referral from a network or panel physician and the referring physician receives approval for the referral before the services are rendered by the non-network/-panel provider subject to further conditions below.

a. The referring physician is responsible for communicating the referral to the carrier and monitoring the progress of the patient. Any subsequent referrals must be made by a panel physician.

b. The carrier is responsible for monitoring referral frequency and patterns, and for ensuring that additional costs are not incurred by the Program or the enrollee.

c. For TCN enrollees living outside the defined TCN service area, benefits will be payable for these services as if they had been provided by a TCN network provider.

d. A service which would not otherwise be a covered service does not become a covered service by virtue of a referral.

e. Benefits payable for covered services are subject to any applicable co-payments, co-insurances, deductibles, or out-of-pocket maximums for which the enrollee is responsible for as set forth in Article II, Section 4. of this Program.

B. Benefit Period Provisions

1. An enrollee is entitled to a maximum of three hundred sixty-five (365) days of covered inpatient hospital services for each continuous period of hospital confinement or for successive periods of confinement separated by less than sixty (60) days; however,

a. The inpatient treatment of pulmonary tuberculosis is limited to forty-five (45) days of the benefit period.

b. An enrollee is entitled to two (2) days of inpatient skilled nursing facility care for each remaining day of the inpatient hospital benefit period, up to a maximum of seven hundred thirty (730) days for each continuous period of confinement or for successive periods of confinement separated by less than sixty (60) days.

c. An enrollee is entitled to three (3) home health care visits for each remaining day of the inpatient hospital benefit period, as long as the enrollee is medically eligible. Each visit by a member of the home health care team, each approved outpatient visit to a hospital or skilled nursing facility, and each home health aide visit is considered the equivalent of one (1) home health care visit. A home health care visit will be

counted even though the enrollee is not seen if the visit is made in good faith (i.e., the agency is not notified prior to the visit that the patient is not available). IV infusion therapy visits shall not be counted as home health care visits.

d. An enrollee is entitled to a lifetime maximum of 365 days of hospice care without impact on the inpatient hospital benefit period. The hospice benefit period may be extended beyond 365 days if the enrollee obtains authorization from the carrier's case management program. In addition, an enrollee is entitled to a life time maximum of 28 pre-hospice visits prior to the election of hospice benefits.

2. The relationships between the various benefit period maximums are set forth below:

a. Each day of inpatient hospital care reduces by two (2) the number of days of care available for skilled nursing facility services. Days of care in a skilled nursing facility do not reduce the number of days of inpatient hospital care.

b. Each day of inpatient hospital care reduces by three (3) the number of visits available for home health care services. The number of home health care visits used will not reduce the number of inpatient hospital or skilled nursing facility days to which the enrollee is otherwise entitled.

3. Benefit periods for physician services and medical care related to hospital inpatient admissions and skilled nursing facility admissions are related to or may be determined concurrent with the benefit periods for facility services as noted below.

a. For conditions other than pulmonary tuberculosis, an enrollee is entitled to coverage for medical care for the duration of the hospitalization.

b. Coverage of medical care for pulmonary tuberculosis is limited to forty-five (45) days for the treatment of tuberculosis for each continuous period of confinement or for confinements separated by less than sixty (60) days.

c. For conditions other than tuberculosis, an enrollee is entitled to a benefit period of seven hundred thirty (730) days of medical care in a skilled nursing facility for each continuous period of confinement or for successive periods of confinement separated by less than sixty (60) days. No coverage is available for medical care in a skilled nursing facility for the treatment of tuberculosis.

(1) Coverage for medical care in a skilled nursing facility is limited to a maximum of two (2) visits per week.

(2) If the enrollee is admitted to a skilled nursing facility within sixty (60) days of discharge from a hospital, each day of hospital inpatient medical care reduces by two (2) the number of days of medical care available in a skilled nursing facility.

4. Benefit periods may be renewed, subject to the provisions below:

a. The benefit periods specified in subsection B.1. are within the general benefit period for inpatient hospital services. Consequently, to be eligible for further benefits under each of the subsections, there must be a separation of sixty (60) days between periods of hospitalization for any reason.

b. A new benefit period begins only when the enrollee has been out of care (as described below) for a continuous period of sixty (60) days. Accordingly, there must be a lapse of at least sixty (60) consecutive days between the date of the enrollee's last discharge from any hospital, skilled nursing facility, residential substance abuse treatment facility, or any other facility to which the sixty (60) day benefit renewal period applies and the date of the next admission, irrespective of the reason for the last admission and irrespective of whether or not benefits were paid as a consequence of such admission. Further, if subsequent to such discharge, the enrollee is a patient in a psychiatric or substance abuse day or night care program, a substance abuse halfway house or is receiving home health care visits, the 60-day renewal period is broken, whether or not benefits were paid as a consequence of receipt of such services.

C. Access to Information

In order to ensure proper administration and to facilitate the ongoing evaluation of this Program:

1. Enrollees shall authorize providers of services to furnish to the carrier(s), upon request, information relating to services to which the enrollee is, or may be, entitled under this Program.

Providers of services shall be authorized to permit the carrier(s) to examine their records with respect to the services and to submit reports of the services in the detail requested by the carrier(s). All information related to treatment of the enrollee will remain confidential except for the purpose of determining rights and liabilities arising under this Program.

2. A provider claiming payment from the carrier must furnish a report to the carrier, in the prescribed form, within one hundred eighty (180) days from the date of the last continuous service listed on the report as having been rendered to the enrollee. The provider must certify upon the report that the provider is entitled to payment under this Program and that the service was personally rendered or rendered during the provider's presence and under the provider's supervision. An enrollee's request for service is authorization to the provider to make the report.

3. An enrollee seeking payment from a carrier must furnish, or cause the provider to furnish, a report to the carrier in the form prescribed by the carrier. By filing the report the enrollee consents that the carrier may have access to the data disclosed by the records and files of the provider and of the hospital or other facility named in this report.

D. Identification Cards

1. Enrollees shall be furnished identification cards by the carrier(s). Such cards shall contain toll-free telephone numbers for obtaining predetermination information or other required approvals of services.

2. The identification card must be presented when service is requested.

3. An enrollee shall not use an identification card to obtain benefits to which such enrollee is not entitled, nor shall the enrollee permit another person to obtain benefits to which such person is not entitled.

E. Medicare

1. Medicare As A Secondary Payer To The Program

Under current Federal laws, certain enrollees otherwise eligible to enroll for benefits under Medicare, may defer enrollment in Medicare without penalty. If such enrollees are not eligible for coverage under any other employer plan or program and elect to enroll in Medicare, the Program remains the primary source of benefits, with Medicare supplementing Program coverage. For purposes of subsection 2 below, Medicare enrollment of such enrollees shall be disregarded. The cited subsection will not be disregarded if Medicare is the primary payer of benefits relative to the Program, but is secondary to another plan or program. In the latter case, the Program carriers will process the claim after the primary plan/program and Medicare have processed the claim, and will apply the provisions of subsection 2, below.

2. The Program As A Secondary Payer to Medicare

a. Medicare Part A (Hospital Insurance) Program enrollees who are eligible to enroll for primary benefits under Part A of Medicare, whether or not they are enrolled, will have all coverage available under this Program reduced to the extent payment or benefit is available (or would have been available had the eligible enrollee been enrolled for Medicare benefits) under Part A of Medicare. The hospital coverage under this Program will be reduced during the additional Medicare sixty (60) day lifetime maximum for inpatient hospital benefits, to the extent the benefits are available under Medicare whether or not the enrollee utilizes the lifetime reserve.

b. Medicare Part B (Medical Insurance)

(1) Until July 1, 2008, only those Program Enrollees who are enrolled for benefits under Part B of Medicare will have all coverage available under this Program reduced to the extent that payment or benefit is available under Part B of Medicare.

(2) Effective July 1, 2008, Program enrollees who are eligible to enroll for benefits under Part B of Medicare, whether or not they are enrolled, will have all coverage available under this Program reduced to the extent payment or benefit is available (or would have been available had the eligible enrollee been enrolled for Medicare benefit) under Part B of Medicare. Further, except in the case where the enrollee does not have the ability to control or select a provider who accepts Medicare assignment, any additional amounts incurred over the Medicare allowed amount will be considered non-covered expense under the Program. Such additional amounts will be the Program enrollee's responsibility and will not count toward any enrollee cost-sharing provisions of the Program.

c. All benefits furnished under Medicare Part A and/or Part B, or which would have been furnished had the enrollee been enrolled for Medicare Part A and/or Part B benefits will be charged against the maximum benefit periods and maximum benefit amounts under this Program. Reduction of coverage under this provision or charging of Medicare benefits against the maximum benefit periods and maximum benefit amounts of this Program will be limited to the benefits provided by Medicare which would have been provided under this Program in the absence of this subsection.

d. Certain pharmaceutical products may be eligible for reimbursement under Parts A and/or Parts B of Medicare. Such pharmaceutical products are not the self-administered products covered under Part D of Medicare and/or under Section III.G. of this Appendix. As soon as practical, Program enrollees with Medicare as their primary coverage will be expected to facilitate the filing of claims through Medicare (e.g., by assigning Medicare benefits to those providers from which the enrollee receives the medications) before seeking Program reimbursement. The appropriate carriers will be expected to facilitate the enrollee process for filing claims with Medicare. If an enrollee utilizes a provider who does not have the ability to submit a claim to Medicare, the enrollee will be required to seek reimbursement for the pharmaceutical products received directly from Medicare and thereafter from the Program. Any applicable enrollee cost-sharing will be applied to the secondary balance remaining after Medicare processing.

e. Medicare Part D (Prescription Drug Coverage) The Program currently provides prescription drug coverage that is considered “creditable coverage” or the actuarial equivalent of coverage offered under Part D of Medicare. Accordingly, Program enrollees who are eligible for Part D and elect to enroll in it will have their prescription drug coverage under the Program suspended for any period of Part D enrollment. As long as the enrollee remains covered by Medicare Part D, the Program will not reimburse the Part D premium or any other amount associated with the enrollee’s prescription drug expenses that might otherwise be covered under Appendix A, Section III.G. of the Program.

F. Medical Necessity

1. All covered services under the Program are subject to a requirement of medical necessity (see App. A, IV.H.).

2. The Control Plan will establish criteria, where necessary, to define medical necessity and accepted uniform standards of medical practice for the purposes of determining covered services. The Control Plan shall propose such criteria to the Company, and when such criteria are approved, shall communicate them to the local carriers. Local carriers shall communicate the criteria to providers.

3. Local carriers, or others, requesting establishment, revision or withdrawal of such criteria shall submit such requests to the Control Plan for consideration. The Control Plan shall advise the Company of all such requests and recommended dispositions.

G. Legal Action by an Enrollee

No action by an enrollee for entitlement to benefits under this Program may be brought more than two (2) years after such claim has accrued; provided, however, no other actions may be brought against the Program at all more than six (6) months after such claim has accrued.

H. Changes in the Program

1. Any rate of payment by the enrollee and any other terms and conditions of the Program may be changed at any time by the Company. Reasonable notice of such changes will be furnished to enrollees and/or affected parties as necessary.

2. From time to time additional coverages may be provided or existing coverages withdrawn by the Company. In either event adequate notice shall be given to providers and/or enrollees, as appropriate, by the Company and/or the carrier(s).

3. Neither the Control Plan nor a local carrier may make a substantive change to the coverages or benefits without prior approval of the Company. This includes amending administrative practices, policies or interpretations that in the judgment of the Company would materially affect the benefits of the Program.

I. Approval of New Services, Technologies and Provider Classes

1. A procedure has been established and will be followed for implementing the addition of new or revised services or items to this Program.

2. A proposal for the inclusion in the Program of a new or revised service or item may be submitted to the Control Plan by a carrier, a physician or physician group, a professional organization, a provider or provider group, the Company or a union representing employees to whom the Program applies.

3. The Control Plan shall review such proposal and make a written recommendation to the Company regarding whether or not the service or item should be added to the Program. Such recommendation shall include, but not be limited to, the following:

a. Any quality of care concerns and proposed steps to ensure quality delivery of the service if approved;

b. Any access concerns and proposed actions to resolve such concerns;

c. Any concerns over appropriate utilization and proposed actions to resolve such concerns;

d. Any service(s) being replaced by the new service, and a plan for discontinuation of coverage for the replaced service;

e. Positive or negative impact on Program costs; and

f. Plan options for which the service or item is recommended.

4. The Company shall review and approve or disapprove the Control Plan recommendations. If approval is given and the service or item is added, an effective date will be established. Only services or items provided on or after the effective date will be covered.

5. The Control Plan will advise local carriers of any approved additions to the Program, the effective dates, and/or limitations or special provisions that apply. The local carriers will advise providers.

III. Description of Coverages

A. Hospital Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered expenses incurred in a hospital only if the following conditions have been met:

a. The admission and length of stay have predetermination approval for non-emergency admissions and within 24 hours of emergency admissions from the carrier for enrollees in the TCN option, as set forth in Article II, Section 4.

b. Services are received on or after the enrollee's effective date of coverage in the Program.

c. For inpatient hospital services, the enrollee is admitted in accordance with the Program provisions, as administered by the carrier, and the hospital's rules and regulations governing admission as a bed patient, and is under the constant care and treatment of a physician during the period of admission.

d. For inpatient hospital services, the enrollee has benefit days available under the hospital benefit period as set forth in Section II.B. above.

2. Inpatient Hospital Coverage

Upon admission to a participating hospital, or to any hospital for carriers without participating arrangements, an enrollee is entitled to receive the following services when prescribed by the physician in charge of the case, approved by the carrier or preferred provider organization (see App. A, II.A.), and provided and billed by the hospital:

a. Semiprivate room, general nursing services, meals, and special diets. Private room coverage will be provided only when such accommodations are medically necessary as set forth in the Informed Choice Plan Administration Manual published by the Control Plan;

b. Use of operating rooms, other surgical treatment rooms, and delivery room;

c. Anesthesia services, anesthesia supplies, gases, and use of equipment;

d. Laboratory and pathology examinations which are under the direction of a pathologist employed by the hospital;

e. Chemotherapy for the treatment of malignant diseases by chemical antineoplastic agents except when treatment is research or experimental in nature;

f. Physical, speech, and functional occupational therapy (see App. A, III.C);

g. Oxygen and other gas therapy;

h. Drugs, biologicals, and solutions used while the enrollee is in the hospital;

i. Gauze, cotton, fabrics, solutions, plaster, splints, and other materials used in dressings and casts;

j. Radioactive isotope studies and use of radium when the radium is owned or rented by the hospital;

k. Maternity care and routine nursery care of the newborn during the hospital stay of the mother for maternity care, when the mother is an enrollee. Coverage will comply with the Newborns' and Mothers' Health Protection Act of 1996;

l. Hospital service in a special care unit;

m. Blood services, including blood derivatives, blood plasma, supplies and their administration. As of January 1, 2004, whole blood and packed red blood cells are covered expenses. Body component preservation and storage for future use are not covered expenses;

n. Hemodialysis when provided by a hospital qualified to provide hemodialysis treatment. The determination of the carrier as to whether or not a hospital is a qualified hospital for providing hemodialysis is final;

- o.** Durable medical equipment (see App. A, III.I.);
- p.** Prosthetic and orthotic appliances (see App. A, III.I.);
- q.** Hospital services for mastectomy or for sterilization of male or female enrollees, regardless of medical necessity;
- r.** Hospital services for covered plastic, cosmetic and reconstructive surgery (effective June 1, 2006 hospital services for non-covered plastic, cosmetic and reconstructive surgery are not covered and are the enrollee's responsibility);
- s.** Hospital services for abortions regardless of the medical necessity for the abortion;
- t.** Pulmonary function evaluation;
- u.** Skin bank, bone bank and other tissue storage bank costs when required by, and performed in conjunction with, another covered service;
- v.** Inhalation therapy when performed in conjunction with another covered service;
- w.** Human organ and tissue transplants. For hospitalization for medically recognized human organ or tissue transplants from a living or cadaver donor to a transplant recipient, hospital services (including evaluation tests to establish compatibility and suitability of potential and actual donors when the tests cannot be done safely and effectively on an outpatient basis) are provided as follows:

(1) When the transplant recipient and the donor are both enrollees, benefits are provided for both;

(2) When the transplant recipient is an enrollee, but the living donor is not, benefits are provided for the transplant recipient and, to the extent they are not available under any other health care coverage, for the donor;

(3) When the living donor is an enrollee and the transplant recipient is not, benefits are provided only for the donor;

(4) When the transplant recipient is an enrollee, expenses incurred in the evaluation and procurement of cadaver organs and tissues are benefits when billed by the hospital. All such expenses will be charged to the enrollee's coverage to the extent that they are not covered by any other health care coverage of the donor or potential donor.

(5) For purposes of this subsection w. and App. A, III.E.3.a.(3), "medically recognized" human organ or tissue transplants include allogeneic bone marrow for only specified diagnoses, autologous bone marrow for only specified diagnoses, cornea, heart, heart/lung, kidney, liver, kidney/liver, lung, pancreas, simultaneous pancreas/kidney, lobar lung, small intestine, small bowel/liver and skin.

3. Outpatient Hospital Coverage

a. When an enrollee receives outpatient hospital services in a participating hospital, or any hospital for carriers without participating arrangements, which have been ordered by the attending physician and approved by the carrier or preferred provider organization (see App. A, II.A.), the enrollee is entitled

to the same coverages available on an inpatient basis, except that:

(1) Drugs, biologicals, and solutions are covered only to the extent they are used in the hospital and administered in connection with the use of operating or surgical treatment rooms, anesthesia, laboratory examinations, other outpatient hospital services, or, as of October 1, 1999, IV infusion therapy services.

(2) Physical therapy, speech therapy and functional occupational therapy also may be covered (see App. A, III.C.).

(3) Chemotherapy (chemotherapeutics, antineoplastic agents and necessary ancillary drugs and their administration) is provided for the treatment of malignant diseases except when the treatment is research or experimental in nature. Chemotherapy is covered for the following routes of administration: parenteral, continuous or intermittent infusion, perfusion, and intracavitary. Coverage is available for three (3) follow-up visits within thirty (30) days of covered chemotherapy treatments.

(4) Coverage does not include treatment of non-emergent chronic conditions which require repeated visits to the hospital, except for hemodialysis and, as of October 1, 1999, IV infusion therapy services.

(5) Services in the emergency room of a hospital are covered for the initial examination and treatment of conditions resulting from accidental injury or medical emergencies. Follow-up care is not covered, with the exception of follow-up care for rabies exposure (see App. A, III.E.3.o.).

If an emergency room patient or a patient directly referred by a physician or skilled nursing facility is placed under observation care, hospital services are covered when such services are reasonable and necessary to evaluate a patient's condition or determine the need for possible admission to the hospital.

(6) Pulmonary function evaluation is covered in the hospital outpatient setting, in accordance with Program standards.

(7) Hyperbaric oxygenation is covered in the outpatient hospital setting, subject to Program Standards, when medically necessary for treatment of disease or injury.

(8) Inhalation therapy is not covered unless performed in conjunction with another covered service.

(9) Skin bank, bone bank and other tissue storage bank services are not covered when not required by, and performed in conjunction with, another covered service.

(10) Observation care immediately following outpatient surgery or diagnostic testing is covered.

(11) Facility services in urgent care centers as approved by the carrier.

b. Hemodialysis (use of kidney machine) or peritoneal dialysis for the treatment of a chronic, irreversible kidney disease is covered in an enrollee's home when services are incurred, and billed by a hospital which has a hemodialysis program approved by the carrier.

(1) Benefits will not be payable unless the following conditions are met:

(a) treatment must be arranged through the physician attending the enrollee and the physician director or a committee of staff physicians of the training program, and

(b) the owner of the enrollee's residence must give written permission to the hospital for installation of the equipment prior to its installation.

(2) The following are covered expenses under this subsection:

(a) Purchase, lease, or rental of a hemodialysis machine placed in the enrollee's home;

(b) installation and maintenance or repair of a hemodialysis machine placed in the enrollee's home;

(c) hospital expenses for training the enrollee and any individual who will be assisting the enrollee in the home setting in operating the hemodialysis machine;

(d) laboratory tests related to the dialysis procedure;

(e) consumable and expendable supplies required during the dialysis procedure, such as dialysis membrane, solution, tubing, and drugs;

(f) removal of the dialysis equipment from the enrollee's home when the enrollee no longer needs the equipment.

(3) The following are not covered expenses under this subsection:

(a) services not provided and billed by a hospital with a hemodialysis program approved by the carrier;

(b) reimbursement to individuals trained and assisting in the dialysis procedure;

(c) electricity or water used in operating the dialyzer;

(d) installation of electric power, a water supply, or a sanitary waste disposal system in conjunction with installing the dialysis equipment;

(e) physician's services, except to the extent the physician is reimbursed by the hospital for administration and overall supervision of the program;

(f) transfer of the dialyzer to another location in the enrollee's residence;

(g) services performed prior to the effective date of the home hemodialysis program;

(h) services provided by an agency or organization providing "back up" assistance in home hemodialysis, including the services of hospital personnel sent to the enrollee's home, or of other persons under contract with the hospital.

4. Limitations and Exclusions

a. Coverage for hospital services is only for the period which is medically necessary for the proper care and treatment of the enrollee, subject to the maximum

benefit period and other applicable Program provisions. As a condition of continued hospital coverage, the carrier may require written verification by the physician in charge of the case of the need for services.

b. Coverage does not include hospital services related to domiciliary, custodial, convalescent, nursing home, or rest care.

c. Coverage does not include hospital services consisting principally of dental treatment or extraction of teeth, except as provided in App. A, III.E.3.a.(2).

d. Coverage does not include inpatient hospital services when the care received consists principally of observation or diagnostic evaluations, inpatient physical therapy, x-ray examinations, laboratory examinations, electrocardiography or basal metabolism tests, ultrasound studies, nuclear medicine studies, weight reduction by diet control with or without medication, or environmental control.

e. Coverage for hospital services does not include services of physicians, oral surgeons, or services covered elsewhere in this Appendix, such as x-ray examination or therapy, electrocardiography, cobalt, or ultrasound studies.

f. The enrollee must give notice of coverage to any hospital at the time of admission. If notice is not given at that time, the enrollee may be liable for a portion of charges incurred.

g. If an enrollee cannot obtain admission to participating or nonparticipating hospitals, the carrier may pay the enrollee an amount not to exceed sixty-five dollars (\$65) for the expense of nursing and other services and supplies, restricted to the equivalent of

hospital care made necessary by the illness or injury. The payment shall be full satisfaction of all obligations of the carrier and the participating hospitals to furnish hospital service for the disability for which admission was sought; provided, however, that if the admission is for the care of contagious or epidemic disease, or injury due to war, declared or undeclared, the Company, the carriers and the participating hospitals are under no obligation or liability under this Program.

h. Hospital coverage does not include facility charges for care received in a freestanding ambulatory surgery center, unless such center meets Program standards and is approved for benefit payment under the Program.

i. Effective June 1, 2006, hospital coverage does not include inpatient or outpatient services related to non-covered plastic, cosmetic and reconstructive surgery (see App. A, III.E.3.a.(1) for covered services).

j. Coverage for hospital services is subject to the Terms and Conditions of Section II, and Limitations and Exclusions of Section IV.

B. Skilled Nursing Facility Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered expenses incurred in a skilled nursing facility only if the following conditions have been met:

a. The services are received on or after the enrollee's effective date of coverage in this Program;

b. The services have been approved by the TCN carrier or preferred provider organization (see

App. A, II.A.) and the enrollee is admitted to the skilled nursing facility by the order of a physician who certifies that the enrollee requires the type of care available at the facility;

c. The enrollee has benefit period days available under the skilled nursing facility benefit period (see App. A, II.B.);

d. The care received by the enrollee consists of definitive medical, nursing, or other paramedical care.

2. Coverages

a. Upon admission to a participating skilled nursing facility, or to any skilled nursing facility for carriers without participating arrangements, an enrollee is entitled to receive, if approved by the carrier or preferred provider organization (see App. A, II.A.), the following services when prescribed by the physician in charge of the case and when provided and billed by the facility:

(1) Semiprivate room, general nursing service, meals and special diets;

(2) Use of special treatment rooms;

(3) Routine laboratory examinations;

(4) Physical, speech, or functional occupational therapy when medically necessary for the treatment of the enrollee (see App. A, III.C.);

(5) Oxygen and other gas therapy;

(6) Drugs, biologicals, and solutions used while the enrollee is in the facility;

(7) Gauze, cotton, fabrics, solutions, plaster, splints and other materials used in dressings and casts;

(8) Durable medical equipment (see App. A, III.I.)

b. Medical care in skilled nursing facilities: Coverage is provided for medical care approved by the TCN carrier or preferred provider organization (see App. A, II.A.), in a skilled nursing facility by the physician in charge of the case. Care is subject to the 730 day benefit period maximum of two (2) visits per week (see App. A, II.B.3.c.). However, no coverage is available for medical care in a skilled nursing facility for the treatment of tuberculosis or substance abuse.

3. Limitations and Exclusions

a. Skilled nursing facility services are covered only when the services are medically necessary. As a condition of continued skilled nursing facility coverage, the carrier may require written verification by the physician in charge of the case of the need for services.

b. Coverage is not provided for care which is principally custodial or domiciliary or for care of tuberculosis.

c. Notwithstanding a. and b. above, for the period of time the Program is secondary to the payment of Medicare benefits for skilled nursing facility services, Medicare's determination of coverage will be deemed to satisfy Program criteria as to medical necessity and maintenance, domiciliary and custodial care. However, if aware of the admission during such period of time, the Control Plan, or another designated party, shall review the admission and advise the enrollee as to ongoing coverage before the exhaustion of Medicare benefits.

d. Coverage for skilled nursing facility services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

C. Physical, Functional Occupational and Speech Therapy Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for physical, functional occupational and speech therapy covered expenses only if the following conditions have been met:

a. Services are received on or after the enrollee's effective date of coverage in this Program;

b. Services are approved by the TCN carrier or preferred provider organization (see App. A, II.A.), and prescribed by the physician in charge of the case and are provided or supervised by a registered and licensed physical, occupational or speech therapist for the specific therapy prescribed (i.e., a registered and licensed occupational therapist need not be supervised by a registered and licensed physical therapist);

c. Services are provided in and billed by:

(1) a freestanding outpatient physical therapy facility, home health care agency or skilled nursing facility approved by the carrier or preferred provider organization;

(2) a hospital; or

(3) an independent physical, occupational, or speech therapist, or physician who is participating with or approved by the carrier; and

d. Benefits are available during the benefit period for covered inpatient care or home health care services (see App. A, II.B.) or within the 60-visit maximum for outpatient care (see subsection 2., below).

2. Benefit Maximums

a. An enrollee admitted to a hospital or skilled nursing facility as an inpatient or to a home health care program is entitled to unlimited physical, functional occupational and speech therapy services rendered during the applicable benefit period (see App. A, II.B.).

b. An enrollee is entitled to receive up to a combined total of sixty (60) physical, functional occupational and/or speech therapy visits per condition in any calendar year, whether provided in an approved freestanding outpatient physical therapy facility or an approved hospital outpatient department. This benefit period is renewable each calendar year, or immediately following a distinct aggravation of, or surgery related to, the condition for which outpatient therapy benefits were originally paid.

c. Multiple therapy treatments occurring on the same day are considered a single visit.

d. In the event an enrollee is entitled to benefits under subsection 3.b.(3) below, there is a separate 60-visit speech therapy benefit available.

3. Coverages

Physical, functional occupational and speech therapy services are covered as follows:

a. Physical Therapy and Functional Occupational Therapy

(1) Upon admission to a hospital or skilled nursing facility, an enrollee is entitled to receive physical and functional occupational therapy to the extent medically necessary for the treatment of the condition for which the enrollee is admitted.

(2) Enrollees are entitled to receive physical therapy or functional occupational therapy provided through an approved home health care agency. When special equipment not easily made available in the home is required, an enrollee is entitled to coverage for physical or functional occupational therapy and speech evaluation in a hospital or freestanding outpatient physical therapy facility participating in the home health care program when related to the condition for which the enrollee was admitted to the home health care program. The normal limitation on visits for outpatient physical, functional occupational and speech therapy does not apply to this provision. Instead, the home health care benefit entitlement applies.

(3) Enrollees are entitled to receive physical therapy, occupational therapy, and speech therapy provided in an office setting by an independent physical, occupational or speech therapist meeting Program standards or by a physician. The provider must be participating with or approved by the carrier. Such treatments are subject to the benefit maximum in subsection 2.b above. Physical therapy provided by an independent physical, occupational, or speech therapist, or physician who is not participating with or approved by the carrier or preferred provider organization is not covered.

b. Speech Therapy

(1) Upon admission to a hospital or skilled nursing facility, an enrollee is entitled to receive speech therapy on the same basis as described in subsection 3.a.(1) above.

(2) Speech therapy (speech pathology) 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, unless provided by an approved home health care agency, in which case the home health care benefit period maximum applies (see App. A, II.B.). Speech therapy is not covered for long standing, chronic conditions, or inherited speech abnormalities except as set forth in subsection b.(3) below.

(3) Speech therapy for congenital and severe developmental speech disorders is a covered service when not available through other public agencies (e.g., state or school), up to sixty (60) visits annually.

(a) Such therapy must be provided only through an approved hospital outpatient facility, freestanding outpatient physical therapy facility, office setting, or home health care agency.

(b) In order to be covered, the enrollee must be diagnosed as having a severe communicative deficit as defined by Program standards.

(c) Speech therapy is not covered for the following conditions:

(i) Educational learning disabilities (e.g., dyslexia);

(ii) Deviant swallow or tongue thrust;
and

(iii) Mild developmental speech or language disorders.

(d) Initial and interim patient assessment to determine severity of condition, potential for improvement, progress and/or readiness for discharge from treatment is considered part of the overall treatment program and is a covered service when accompanied by treatment.

(e) Steady improvement as a consequence of treatment must be documented. Such documentation must be available to the carrier upon request.

4. Limitations and Exclusions

a. Coverage for physical therapy services is available only if:

(1) it is provided with the expectation that the condition will improve in a reasonable and generally predictable period of time, or

(2) improvement is noted on a periodic basis, as documented in the patient's record.

b. Coverage for physical therapy and functional occupational therapy is excluded for treatment of congenital conditions or when provided solely to maintain musculoskeletal function.

c. Coverage is not available for inpatient admissions which are principally for physical, functional occupational and speech therapy.

d. Coverage for physical, functional occupational and speech therapy services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

D. Home Health Care Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for covered expenses incurred for home health care service only if the following conditions have been met:

a. The home health care services are received on or after the enrollee's effective date of coverage in this Program;

b. The enrollee is referred to and accepted by a home health care agency that meets Program standards and is approved by the local carrier;

c. The services received are approved by the TCN carrier or preferred provider organization (see App. A, II.A.), prescribed by the physician in charge of the case and provided and billed by an approved provider;

d. The physician in charge of the case certifies to the carrier that home health care is medically necessary for the care of the enrollee; and

e. Visits are available within the benefit period (see App. A, II.B.).

2. Coverages

a. The following home health care services are covered when provided and billed by a home health care agency approved by the carrier or preferred provider organization:

(1) General nursing services

(2) Physical therapy and speech therapy (may be provided and billed by a hospital outpatient department or freestanding outpatient physical therapy facility under limited circumstances - see App. A, III.C.3.);

(3) Social service guidance, dietary guidance, and functional occupational therapy; and

(4) Part-time health aide service by a home health aide employed by an approved home health care agency. To be eligible for home health aide service, the enrollee must be receiving one of the services in (1) or (2) above, and it must be determined by the home health care agency that the enrollee could not be treated under this subsection without the home health aide service.

b. The following services are covered when provided and billed by an approved provider:

(1) Laboratory tests;

(2) Drugs, biologicals, and solutions; and

(3) Medical supplies which are essential in order to effectively administer in the home the medical regimen ordered by the physician. Supplies include items such as bandages, dressings, splints, hypodermic needles, catheters, colostomy appliances, and oxygen.

c. IV infusion therapy services in the home are covered under home health care coverage. The following provisions will apply to such services:

(1) The “homebound” requirement will be waived with respect to home infusion therapy patients;

(2) Related nursing services will be included;

(3) Applicable prescription drugs will be included;

(4) All services directly related to infusion therapy, including DME, parenteral and enteral methods of hyperalimentation, chemotherapy, and supplies, will be covered under Home Health Care coverage;

(5) The provision that limits home health care benefits to three visits for each remaining inpatient hospital day will be waived; and

(6) Home IV infusion therapy services will be covered only when delivered by a provider that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

3. Limitations and Exclusions

a. Coverage for home health care services is available only when the services are medically necessary. As a condition of continued home health care coverage, the carrier may require written verification by the physician in charge of the case of the need for services.

b. Coverage under this subsection does not include supplies such as elastic stockings and personal

comfort items or equipment and appliances such as hospital beds, oxygen tents, walkers, wheelchairs, or orthotics.

c. Coverage under this subsection does not include physician services, private duty nursing services or housekeeping services.

d. Coverage for home health care services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

E. Surgical and Medical Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for expenses incurred for surgical and medical covered services only when the following conditions have been met:

a. Services are received on or after the enrollee's effective date of coverage in this Program;

b. Services are approved by the carrier or preferred provider organization (see App. A, II.A.); and

c. Services are received prior to the termination date of the enrollee's coverage, except that services received during hospital admissions which commence prior to such termination date will be covered subject to other provisions of this Program.

2. Payment of Services

a. The carrier(s) will make payment according to the network or panel allowed amount. The carrier(s) will defend enrollees from any TCN network or PPO panel provider's attempts to collect in excess of the allowed amount for covered services.

b. A carrier will make the benefit payments directly to the provider for services performed or materials furnished by such provider, or directly to the enrollee if appropriate.

c. With the exception of situations discussed in subsection d. below, enrollees will be responsible for amounts charged by non-TCN network or non-PPO panel providers that are in excess of the carrier's allowed amount. Notwithstanding the personal expense limits described in Article II, Section 4 of the Program, an individual enrollee's liability is without limit for all amounts charged by a non-network or non-panel provider over and above the TCN carrier's allowed amount for the covered services provided.

d. The provisions of subsection c., above, will not apply in the case of an enrollee who is referred out of network or off-panel by a network or panel provider, or in the case of an enrollee who, as determined by Program standards, has no control over the choice of provider. In such cases the carrier will make payment based upon the lesser of the provider's charge or the carrier's allowed amount for the service. A carrier's determination, made in good faith, of the allowed amount is conclusive. The carrier will defend its determination of the allowed amount if a provider claims an amount in excess of the allowed amount and there is no prior written agreement between the enrollee and the provider regarding the amount of the provider's charges.

e. Certain hospital-based physician services billed by a hospital will be paid directly to the hospital by a carrier according to the carrier's agreement with the hospital.

3. Coverages

Except as otherwise indicated, the following services are covered:

a. Surgery: Subject to the limitations listed below, surgical services, consisting of generally accepted operating and cutting procedures for the necessary diagnosis and treatment of diseases, injuries, fractures, or dislocations, are covered when performed by the physician in charge of the case.

Surgical services include usual, necessary, and related preoperative and postoperative care performed in or out of the hospital.

(1) Plastic and reconstructive surgery is limited to the correction of congenital anomalies and conditions resulting from accidental injuries or traumatic scars, to the correction of deformities resulting from cancer surgery or following medically necessary mastectomies (including medically necessary mastectomies resulting from cancer or fibrocystic disease), and to blepharoplasties when there is secondary visual impairment resulting from conditions such as Bell's Palsy.

Notwithstanding the above, in compliance with the Women's Health and Cancer Rights Act of 1998, in the case of an enrollee who undergoes a mastectomy and who 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; and prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

(2) Dental surgery is limited to multiple extractions, removal of one or more unerupted teeth, alveoloplasty, or gingivectomy, and is covered only when performed in a facility setting (i.e., hospital inpatient or outpatient or FASC), when a concurrent hazardous medical condition exists and when Program standards are met.

(3) Human organ or tissue transplants: For medically recognized human organ or tissue transplants from a living or cadaver donor to a transplant recipient which requires surgical removal of a donated part, benefits for services as listed and limited in this subsection (including laboratory services for evaluation tests to establish a potential donor's compatibility and suitability) will be provided in the same manner as under Section III.A.2.w.

Payments will be reduced by any amount payable from other sources, such as foundations, grants, governmental agencies or programs, research or educational grants and charitable organizations.

(4) Surgical procedures for mastectomy or for sterilization of male and female enrollees are covered, regardless of medical necessity. Sterilization reversals are not covered.

(5) Laser surgery is covered if the alternative cutting procedure is covered. The maximum benefit payable for laser surgery is the carrier allowed amount for the alternative cutting procedure.

(6) Hemodialysis services are covered only when performed in a facility meeting Program standards and approved by the local carrier.

b. Anesthesia: Services for the administration of anesthetics are covered, when provided by a physician, other than the operating physician, and when required by, and performed in conjunction with, another covered service.

(1) Anesthesia services provided by a physician for covered services are payable in all settings that are appropriate for the covered surgical or diagnostic service being performed, including inpatient hospital, outpatient hospital, free-standing ambulatory surgical center, and physician's office.

(2) Coverage may be provided for the services of an Anesthesia Assistant (AA) who meets Program Standards and is approved by the carrier for reimbursement in accordance with their training and licensure. Anesthesia services performed by AAs are payable in the inpatient hospital, outpatient hospital or free-standing ambulatory surgery center settings.

(3) Administration of local anesthetics is not covered. Anesthesia services, supplies, gases and use of equipment provided by a hospital are covered under Section III.A.2.c.

c. Technical surgical assistance: Services by a physician or a non-physician practitioner who actively assists the operating physician are covered when medically necessary and when related to covered surgical or maternity services. In order for the services of the assistant surgical physician or physician assistant to be covered, it must be certified that the services of interns, residents, or house officers were not available at the time.

d. Maternity care: Obstetrical services of a physician including usual prenatal and postnatal care, are covered. For each pregnancy, coverage is also provided for routine prenatal laboratory examinations which are performed in connection with normal maternity care.

(1) The coverage includes the initial hospital inpatient examination of a newborn child by a physician other than the delivering physician or the physician administering anesthesia during delivery.

(2) Obstetrical services of a physician for an abortion are covered only when the abortion is medically necessary.

e. Medical care in hospitals: Inpatient hospital medical care by the physician in charge of the case is covered for conditions, diseases, or injuries (except mental health and substance abuse which is provided for in Appendix B) for which care is different in kind and nature from that customarily provided and considered to be surgical or obstetrical provided benefits are available within the benefit period (see App. A, II.B.).

f. Medical care in skilled nursing facilities: Coverage is set forth in App. A, III.B.2.b.

g. Consultations: While an enrollee is an inpatient in a hospital or skilled nursing facility, and when requested by the physician in charge of the case, coverage is provided for the assistance of a physician in the diagnosis or treatment of a condition which requires special skill or knowledge.

This coverage does not include staff consultations required by a facility.

h. Emergency treatment: Coverage is provided for the services of one or more physicians for the initial examination and treatment of conditions resulting from accidental injury or medical emergencies. If an emergency room patient is placed under observation care, physician services for further examination and treatment will be covered in connection with coverage for hospital services under App. A, III. A.3.a.(5).

If the treatment is in a hospital outpatient department, payment is made only to a physician who is not an employee of the hospital. Follow-up care is not covered.

i. Chemotherapy: Coverage for chemotherapy is provided under App. A, III.A.2.e. for inpatient care and under App. A, III.A.3.a. (3) for outpatient care. Chemotherapy administered in a physician's office is covered on the same basis as outpatient.

j. Extra corporeal shock wave lithotripsy (ESWL): Coverage is provided for services rendered in an approved facility and meeting Program standards.

k. Therapeutic radiology: Coverage is provided for treatment of conditions by x-ray, radium, radon, external radiation, or radioactive isotopes (e.g., cobalt), and includes the cost of materials provided which are not supplied by a hospital.

l. Diagnostic radiology: Subject to any applicable Program Standards, utilization review processes and approval by the carrier, coverage is provided for diagnosis of any condition, disease, or injury by x-ray, ultrasound, isotope examination, computerized axial tomography (CAT), magnetic resonance imaging (MRI), positron emission tomography (PET), coronary computed tomography angiography (CCTA),

mammography and other modalities. Coverage restrictions include, but are not limited to, the following:

(1) Computerized axial tomography is a covered procedure for diagnostic examinations of certain parts of the body (body scans) when ordered by a physician and performed on approved equipment in accordance with Program standards.

(2) Coverage for diagnostic radiology does not include miniature x-ray plates, screening procedures, chest fluoroscopies, or any examination or procedure not directly related and necessary to diagnosis.

(3) Digital subtraction angiography is a covered procedure if performed on hospital based equipment and billed by the hospital.

(4) Magnetic resonance imaging (MRI) benefits will be limited to the carrier determined rate for the applicable geographic area.

(5) Non-screening mammograms used to confirm a diagnosis of cancer or to track the progress of the disease and to determine the effectiveness of treatment being given are covered.

(6) Coronary computed tomography angiography (CCTA) is limited to diagnostic testing subject to carrier approval. CCTA for screening purposes are a benefit exclusion.

m. Diagnostic laboratory, pathology and other services:

(1) Coverage is provided if approved by the carrier for laboratory and pathological examination for the diagnosis of any condition, disease, or injury.

In addition to examinations of blood, tissue, and urine, diagnostic laboratory and pathology include laboratory procedures such as electrocardiograms, electroencephalograms, electromyograms, and basal metabolism tests.

Routine laboratory services in connection with normal maternity care are provided according to the provisions of Section III. E.3.d.

(2) Coverage is provided for laboratory and pathological services for Papanicolaou (PAP) smears when specifically prescribed for one of the following conditions: previous surgery for a vaginal, cervical, or uterine malignancy; presence of a suspect lesion in the vaginal, cervical, or uterine areas as established through clinical examination; or a positive PAP smear leading to surgery and requiring a post-operative smear.

(3) Proctoscopic examinations with biopsy are covered.

(4) Two dimensional echocardiography is a covered procedure if recommended or performed by a board certified or board eligible cardiologist.

(5) When a covered diagnostic test requires injection of a drug, biological or solution in order to perform the test, the drug, biological or solution and the injection of it are covered, subject to carrier billing and reimbursement practices. For purposes of this subsection only, injections of thyrogen are covered in conjunction with covered thyroid scans.

(6) Non-screening PSA tests used to confirm a diagnosis of cancer or to track the progress of the disease and to determine the effectiveness of treatment being given, are covered.

(7) Audiometric tests and hearing evaluation services used to diagnose any condition, disease, or injury of the ear, are covered.

n. Preventive Services: The services listed below are covered as preventive measures. When rendered by network providers they are exempt from deductibles, co-payments or co-insurance that might otherwise apply. When rendered by non-network providers 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 the regular Program provisions (e.g., requirements that the services be medically necessary and appropriate and rendered for diagnosis or treatment of disease or injury) and will be subject to any applicable cost-sharing features.

(1) Papanicolaou (PAP) Smear: Coverage is provided for laboratory and pathological services for one (1) routine screening Papanicolaou (PAP) smear per female enrollee per year to detect cancer of the female genital tract.

(2) Proctoscopic Examinations Without Biopsy: Coverage is provided for one (1) screening exam every three (3) calendar years, after age 40 is attained.

(3) Well Care: Coverage is provided for up to eight (8) visits for babies under one (1) year of age, six (6) well visits from 13 months through 23 months, six (6) well visits from 24 months through 35 months, two (2)

well visits from 36 months through 47 months, and one (1) health maintenance exam per year from 48 months through adulthood.

(4) Immunizations and vaccinations: Coverage is provided for administration of the immunizations and vaccinations used to prevent the diseases or conditions identified below. Based on the recommendations and approvals provided by the Advisory Committee on Immunization Practices (ACIP), coverage may be provided for additional immunizations and vaccinations for the diseases and conditions listed below. Such expansions will be subject to the procedure for approval of new services (Appendix A, II.I). The Control Plan will maintain a current list of covered immunizations and vaccinations meeting Program Standards, including appropriate doses, ages, and frequency of administration. Serum is covered only when it is not supplied by a health department or other public agency. Facility charges associated with immunizations are not covered. Carriers are responsible for monitoring and enforcing appropriate billing and reimbursement practices with respect to any concurrent office visits.

Covered immunizations and vaccinations include those used to prevent the following disease or conditions:

- (a) Diphtheria;
- (b) Tetanus;
- (c) Pertussis;
- (d) Poliomyelitis;
- (e) Haemophilus influenza type B (HIB);
- (f) Pneumococcus bacterium infection (i.e. pneumonia);

- (g) Measles;
- (h) Mumps;
- (i) Rubella;
- (j) Varicella;
- (k) Hepatitis A;
- (l) Hepatitis B;
- (m) Human Papilloma Virus (HPV);
- (n) Rotavirus;
- (o) Meningococcal disease (e.g. meningitis)
- (p) Influenza;
- (q) Zoster (Shingles);
- (r) Cholera;
- (s) Yellow Fever;
- (t) Typhoid;
- (u) Japanese Encephalitis; and
- (v) Rabies

(5) Mammography: Coverage is provided for one (1) routine screening mammography per year starting at age 40.

(6) Prostate Specific Antigen (PSA): Coverage is provided for one (1) screening PSA test per year for enrollees ages forty (40) and older.

(7) Fecal Immunochemical Test: Coverage is provided for one (1) test per year, beginning at age 50.

(8) 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.

(9) ColoGuard Oncology Screening: Coverage is provided for one (1) ColoGuard oncology screening every 3 years.

(10) Total Serum Cholesterol with Low Density Lipoprotein (LDL) Test: Coverage is provided for two (2) tests per calendar year for ages 9-11 then covered one (1) per calendar year.

(11) Hepatitis C (HCV) Screening: Coverage is provided for one (1) Hepatitis C (HCV) screening per year.

(12) Osteoporosis Screening: Coverage provided for one (1) routine osteoporosis screening per year, beginning at age 65.

(13) BRCA Screening: Coverage provided for one (1) each BRCA screening per lifetime.

(14) Other Screenings: Coverage provided for one (1) per year for the following: Chlamydia, Gonorrhea, Hepatitis B, Herpes Simplex Virus, HIV/AIDS, Human Papillomavirus (HPV), and Syphilis.

o. Other Immunizations and Vaccinations: Coverage is provided for administration of certain immunizations and vaccinations which are not considered preventive services (as described in subsection III.E.3.n., above) and are subject to the Program's cost-sharing provisions. The current such immunizations and vaccinations are listed below. Based

on the recommendations and approvals provided by the Advisory Committee on Immunization Practices (ACIP) and/or Medicare, coverage may be provided for additional immunizations and vaccinations. Such expansions will be subject to the procedure for approval of new services (Appendix A, II.I). Serum is covered only when it is not supplied by a health department or other public agency. Facility charges associated with immunizations are not covered. Carriers are responsible for monitoring and enforcing appropriate billing and reimbursement practices with respect to any concurrent office visits.

(1) Treatment for rabies exposure: Coverage is provided for administration of rabies vaccines necessitated by a recent exposure (e.g., by bite, scratch, or exposure to saliva) to a rabid or potentially rabid animal. Coverage does not include rabies vaccine administered for any reason other than a recent exposure.

Whether initial treatment is performed in an emergency room or not, follow-up treatments can be performed in a physician office or hospital outpatient setting.

(2) Respiratory Syncytial Virus (RSV): Coverage is provided for RSV immunizations (e.g., Synagis) for high risk infants.

p. Physician office visits: Coverage is provided for physician office visits to network and panel providers only, subject to the conditions below.

(1) Coverage includes medical visits by a physician when rendered in the physician's office, the home, or the outpatient department of a hospital, for the examination, diagnosis, and treatment of any condition, disease or injury.

(2) Subject to other Program provisions and limitations, the following items may be covered during an office visit:

- (a) history;
- (b) physical examination;
- (c) complete blood count;
- (d) urinalysis;
- (e) vital signs;
- (f) breast examination;
- (g) pelvic examination with PAP smear; and
- (h) injections (diagnostic or therapeutic).

(3) Office visit coverage does not duplicate or replace benefits available under other areas of coverage, such as mental health, prenatal and postnatal care, immunizations, routine eye examinations or substance abuse.

(4) Office visit coverage does not include office visits for:

- (a) insurance and employment examinations;
- (b) manipulation and/or adjustment of subluxation; and
- (c) allergy testing;

(5) Office visits to a non-panel physician, without referral by a panel physician, are not covered.

q. Contraceptive Services: Medical and surgical coverage for contraceptive services is limited to injections of contraceptive medication (professional fees and medication for injection), implantable contraceptives and their insertion or removal, intrauterine devices and their insertion or removal, cervical caps and their fitting, and the fitting of diaphragms. Coverage under this Section does not include over-the-counter contraceptive devices or diaphragms. See Appendix A.III.G. for prescription drug coverage provisions regarding oral contraceptives, injectable contraceptive medication, contraceptive patches and diaphragms.

r. Platelet derived growth factor is covered for wound healing for certain conditions as approved by the carrier.

s. Urgent Care Centers: Services covered include medical or surgical procedures, laboratory tests and radiology tests which are currently payable in a physician office setting.

t. Routine costs associated with approved clinical trials according to Medicare policy.

4. Limitations and Exclusions

a. Dental services, including extraction of teeth, except as provided for in Section III. E.3.a.(2), are not covered under this subsection.

b. Examinations and tests in connection with research studies, screening procedures, premarital examinations, or similar examinations or tests not required in and directly related to diagnosis of illness or injury, except as specifically provided for in this Appendix, are not covered.

c. Coverage for surgical and medical services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

d. Facility charges in the physician's office or a clinic are not covered.

e. Charges for after hours care are not covered.

F. Ambulance Service Coverage

1. Conditions of Benefit Payments

Ambulance services are covered if the following conditions and requirements are met:

a. Ambulance services must be medically necessary. Ambulance services are not medically necessary if any other means of transportation could be used without endangering the patient's health.

b. The ambulance operation providing the service must be licensed and meet Program standards.

c. Transportation (by ground, air or boat ambulance) is provided for purposes of:

(1) transferring (one-way or round trip) a hospital inpatient, or patient seen in the emergency room, from one hospital to another local hospital when lack of needed treatment facilities, equipment or staff physicians exists at the first hospital (in the event the required medically necessary treatment is not available within the local metropolitan area, transfer will be to the closest hospital where such treatment is available), or

(2) transporting (one-way or round trip) a hospital inpatient to a non-hospital facility for a covered

CAT scan, MRI or PET examination provided the following conditions are met:

(a) the services are not available in the hospital in which the enrollee is confined or in a closer local hospital, and,

(b) the facility meets Program standards for providing the services;

(3) Emergency transportation for:

(a) transporting a patient one-way from the scene of an emergency incident to the nearest available facility qualified to treat the patient; or

(b) transporting a patient one-way or round trip from the home to the nearest available facility qualified to treat the patient.

(i) Medical emergency/ accidental injury patients are provided one-way transportation from the home to the facility. Return trip will not be considered medically necessary following stabilization.

(ii) Homebound patients are provided round trip transportation from the home to the facility and back when medically necessary (other means of transportation could not be used without endangering the patient's health).

d. A physician must prescribe the services which necessitate the use of ambulance transportation for services described in c.(1) and (2) above.

e. Air and boat ambulance services are covered only when ground ambulance or other means of transportation could not be used without endangering the patient's health.

2. Coverages

The following services are covered when furnished and billed by an eligible provider (as determined by the carrier) and approved by the carrier:

a. Charges for basic life support services - a standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as basic life support services. Basic life support consists of services which provide for the initial stabilization and transport of a patient.

b. Charges for advanced life support services - a standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as advanced life support services. Advanced life support is acute emergency treatment procedures with physician involvement.

c. Mileage charges - a charge per mile for distances traveled while the enrollee occupies the ambulance.

d. Waiting time - a charge for waiting time involved in round trip transport of an enrollee from a hospital to another treatment site and return to the same hospital.

e. Charges for fixed or rotary wing air ambulance services or boat ambulance services - a standard charge per trip inclusive of use of the air transport or boat transport, supplies and personnel required to perform needed services.

If it is determined that transport by ground ambulance would have sufficed, payment will be limited to the amount that would have been paid for ground

ambulance. The enrollee will be responsible for any balance.

When services are received from an ambulance operation approved by the carrier, the approved provider must agree to accept, as payment in full, the carrier's determination of the amount payable for covered ambulance services.

3. Limitations and Exclusions

a. The following services are not covered as separate charges unless approved by the carrier; such charges are included in the benefit payment for the standard charge per trip:

(1) Use of specific equipment or devices;

(2) Gases, fluids, medications, dressings, or other supplies;

(3) First aid, splinting, or any emergency medical services or personal service procedures; and

(4) Vehicle operators, attendants, or other personnel.

The charges for these services, while not covered as separate charges, are covered as a component of the charge for the basic or advanced life support services.

b. Coverage is limited to the carrier allowed amount for transporting the patient within a metropolitan area or to the nearest facility qualified to treat the enrollee, as appropriate (see Subsection 1.c., above).

c. Coverage does not include the following:

(1) Transportation in a vehicle not qualified as an ambulance;

(2) Transportation for enrollee, family or physician convenience;

(3) Service rendered by fire departments, rescue squads or others whose fee is in the form of a voluntary donation;

(4) Transfers not medically necessary;

(5) Fees, billed by physicians or other independent health care providers, for professional services rendered to enrollees transported by ambulance;

(6) Transportation (one-way or round trip) of an enrollee to a health care facility for the purpose of receiving ESWL services;

(7) Services which are payable through an existing arrangement for transfer of patients, where no additional charge is usually made, whether or not such services were immediately available; and

(8) Coverage for ambulance services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

G. Prescription Drug Coverage

1. Definitions

For the purposes of this subsection:

a. “*brand name drug*” means a drug which is covered by a patent and for which an equivalent version can not be manufactured or marketed (single source) or a drug which is no longer covered by a patent and for which chemically equivalent versions can be manufactured and marketed (multi-source).

b. “*copayment*” means an amount to be paid by the enrollee for each separate prescription order or refill of a covered drug.

c. “*covered drug, supplies or diaphragm*” means insulin, certain vitamins and essential minerals or any prescription legend drug that is dispensed according to a prescription order provided that:

(1) the drug is medically necessary for the treatment of an illness or injury, or is a contraceptive medication;

(2) the cost of the drug is not included or includable in the cost of other services or supplies provided to the enrollee;

(3) the amount of the prescription charge exceeds the copayment;

(4) the drug is customarily dispensed according to a prescription order; and

(5) the drug is not entirely consumed at the time and place of the prescription order.

“*Supplies*” refers to syringes and needles dispensed with self-administered insulin, an antineoplastic agent or other self-injected drug meeting Program standards and covered under the provisions of this subsection.

“*Diaphragm*” refers to a self-administered contraceptive device.

d. “*ED Drugs*” means those drugs which, according to Program standards, are prescribed primarily for the treatment of erectile dysfunction (e.g., Viagra, Levitra, or Cialis).

e. “*generic drug*” means a drug that is chemically equivalent to a multi-source brand name drug.

f. “*nonparticipating provider*” means a provider who has not entered into a contract with the carrier.

g. “*participating provider*” means a provider who has entered into a contract with a carrier to provide a covered drug to an enrollee, in accordance with the provisions of this Program and this subsection. Such contract shall provide for payment to the provider based on prescription charges. In the case of a preferred provider organization which provides prescription drug coverage under the Program, participating providers are the organization’s panel pharmacies.

h. “*pharmacist*” means a person licensed to dispense prescription legend drugs under the laws of the state where such person practices.

i. “*pharmacy*” means a licensed establishment where prescription legend drugs are dispensed by a pharmacist.

j. “*prescription legend drug*” means any medicinal substance which, under the Federal Food, Drug and Cosmetic Act, is required to be labeled “Caution: Federal law prohibits dispensing without a prescription” or “Rx Only.”

k. “*prescription charge*” means a dispensing fee and applicable taxes plus the lesser of the carrier allowed amount or the amount paid by the provider for a covered drug (including insulin and disposable syringes and needles). The “dispensing fee” is an amount or amounts predetermined by the carrier to compensate participating providers for dispensing covered drugs.

For covered drugs obtained from a non-participating provider or from a provider in an area where the carrier does not provide the coverage, the prescription charge means the allowed amount as determined by the carrier.

l. “*prescription order*” means a written or oral request to a provider by a physician for a single prescription legend drug.

m. “*provider*” means a pharmacy or any other organization or person licensed to dispense prescription legend drugs.

n. “*specialty drug*” means certain medications identified in Program standards and targeted at patient populations that have complex diseases. A specialty drug generally requires specialized training for the patient and coordination of care by the patient’s physician prior to therapy initiation. It also requires unique patient compliance protocols and safety monitoring. A specialty drug often has unique handling, shipping and storage needs. It is generally a high cost medication with potential for significant waste. For purposes of determining Program coverage, the identification of a specialty drug is made by the carrier for any prescriptions that not only exceed \$500 per script but brings specialized considerations, such as those items described above. The list of identified specialty drugs may change from time to time and will be maintained on a current basis by the carrier.

2. Reimbursement

a. The copayment amount for each separate prescription order or refill of a covered drug shall not exceed the amounts shown on the chart below:

Dispensed at Retail	
Generic Drugs	\$ 6
Brand Name Drugs	\$12
ED Drugs	\$17
Dispensed through Mail Order	
Generic Drugs	\$12
Brand Name Drugs	\$17
ED Drugs	\$21

b. In addition to the copayment, enrollees may incur additional expense if a brand name drug, other than a drug identified in subsection (4), below is dispensed:

(1) If the brand name drug is dispensed at the enrollee's request, or upon determination that it is not medically necessary to dispense the brand name drug rather than the generic, the enrollee will pay the appropriate generic drug copayment plus the full difference in Program cost between the generic drug and the brand name drug.

(2) If the brand name drug is dispensed at retail and at physician direction, the enrollee will pay the appropriate brand name copayment plus the difference (up to a maximum of \$10.00) in Program cost between the generic drug and the brand name drug.

(3) Enrollees or their physicians may initiate a review with the carrier of the medical necessity for dispensing the brand name drug rather than the generic.

If the medical necessity is not established, future dispensing will be subject to subsection (1) above.

(4) If it is found that dispensing of the brand name drug rather than the generic was medically necessary, amounts in excess of the brand name copayment will be refunded. The carrier's systems will be adjusted to allow dispensing of the brand name for the duration of the prescription.

(5) "Narrow Therapeutic Index drugs" are those for which small variations in the dose could result in changes in drug safety. In order to remain within a safe and effective range, these medications may require frequent patient monitoring to adjust the dose. When such brand name drugs are dispensed, only the brand name copayment will apply. Drugs currently included in this group are:

- Cyclosporine
- Depakene
- Dilantin
- Lanoxin
- Levothyroxine (including Synthroid)
- Mysoline
- Tegretol

This list may be adjusted from time-to-time as reflected in Program standards.

c. The copayments specified above are for the days supply referenced in subsection G.3, below. To the extent a particular covered drug, supply or device is pre-packaged in days supply exceeding the specified ones, and cannot be repackaged by the provider, the copayments will be prorated to account for the additional days supply.

d. Effective January 1, 2004, after the original prescription order and two (2) refills, retail purchases of covered drugs identified in subsection 5.b., below (and related supplies, if applicable) are subject to an enrollee copayment of 100% of the Program cost.

e. Except for the amounts indicated above, covered drugs or supplies obtained from a participating provider are covered subject to the Program provisions.

f. Upon proof of payment acceptable to the carrier, an enrollee is entitled to reimbursement from the carrier of seventy-five percent (75%) of the carrier allowed amount for the generic, brand name or ED drug, as applicable, as determined by the carrier after deduction of the appropriate copayment, of covered drugs obtained on a non-emergency basis from a nonparticipating provider located within the area in which the carrier provides coverage. The enrollee may incur additional expense if a brand name drug rather than the generic is dispensed at the enrollee's request or when not medically necessary.

g. Upon proof of payment acceptable to the carrier, an enrollee is entitled to reimbursement from the carrier of one hundred percent (100%) of the carrier allowed amount for the generic, brand name or ED drug, as applicable, as determined by the carrier after deduction of the appropriate copayment, of covered drugs obtained from a provider located outside the area in which the carrier provides coverage or from an in-area non-participating provider in the case of an emergency. The enrollee may incur additional expense if a brand name drug rather than the generic is dispensed at the enrollee's request or when not medically necessary.

3. Coverage

a. At retail, coverage includes up to a 34 day supply of a covered drug. Certain drugs, such as contraceptives, may be subject to Program standards clarifying what is included in “up to a 34-day supply.”

b. At retail, coverage includes a one month supply of disposable syringes and needles when prescribed and dispensed with a one month supply of self-administered insulin, a covered self-administered antineoplastic agent or other self-injected drugs meeting Program standards.

c. At retail, coverage includes two diaphragms per year. Diaphragms are not available through the mail order pharmacy.

d. At mail order, coverage includes up to a 90 day supply of covered drugs and supplies, with a corresponding prescription or refill order. Coverage also includes up to a 90 day supply of covered drugs at participating retail pharmacies with the corresponding mail order copayment. Diaphragms are not available through the mail order pharmacy.

e. Covered vitamins and essential minerals include, and 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.

4. Maximum Allowable Cost Programs

Maximum Allowable Cost or alternative generic substitution programs, are provided by all carriers. All enrollees except those in the Health Maintenance

Organization option will be eligible. Unless precluded by law, or responding to a physician direction or enrollee request, Program providers may substitute a generic drug for the equivalent multi-source brand name drug.

5. Limitations and Exclusions

a. Coverage under this subsection does not include:

(1) any research or experimental agent including Federal Food and Drug Administration approved drugs which may be prescribed for research or experimental treatments;

(2) any charge for a medication being used for a cosmetic purpose, even if the medication is a prescription legend drug;

(3) any charge for devices (other than diaphragms)_or appliances (e.g., orthotics, and other non-medical substances);

(4) any vaccine administered for the prevention of infectious diseases;

(5) antineoplastic agents except those that can be self-administered through subcutaneous or intramuscular injection or in oral dosage form and are not covered under another section of this Appendix;

(6) any charge for administration of covered drugs;

(7) any charge for a covered drug in excess of the quantity specified by the physician, or any refill dispensed after one (1) year from the physician's order;

(8) any charge for more than a thirty-four (34) day supply of a covered drug at retail;

(9) any charge for medications furnished on an inpatient or outpatient basis covered under any other subsection of this Appendix or under any subsection of Appendix B; and

(10) any charge for drugs received prior to the effective date of this coverage.

(11) Dapoxetine

(12) Non-sedating antihistamines

(13) any charge for compounded medications (a medicine that is made of two or more ingredients that are weighed, measured, prepared or mixed according to a prescription order). A member or physician may submit a request for a medical exception, along with supporting physician documentation, which will be evaluated by the pharmacy carrier using current clinical criteria.

b. Certain prescription drugs, that have been identified by the carrier, are covered at retail, at the applicable 34-day copayment, for an original prescription and two (2) refills; thereafter they are covered at mail, at the applicable copayment for up to a 90-day supply, or at retail at 100% copayment of Program costs for up to a 34-day supply. The carrier will maintain a list of these drugs and update the list on a regular basis.

c. Coverage under this subsection is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

6. Pharmacy Network

a. The carrier will maintain a nationwide limited network of participating retail providers (including local and national pharmacy chains, as appropriate), and a mail order pharmacy. The carrier will select network pharmacies, in part, on access and quality assurance criteria. In contracting with providers, the carrier will assure that the providers fully understand the Program's prescription drug coverage provisions, including eligibility requirements and benefit levels. The carrier will negotiate appropriate fees with participating providers.

b. The Carrier will meet standards of quality, service and accessibility (e.g., availability of participating providers within 5 miles of enrollee's residence or closest facility if greater than 5 miles for 90% of enrollees).

c. The Carrier will establish uniform pharmacy protocols, pharmacy auditing procedures, drug utilization review processes, and all quality assurance procedures. Examples of the above include but are not limited to step therapy edits, prior authorization edits, dose and quantity edits, dose duration edits, dose optimization edits, coverage restrictions related to select drugs or select drug classes, or "34-day" and "90-day" provisions.

d. The Carrier will monitor network performance and provide aggregate data on a regular basis. Data reports will include, but not be limited to, information such as utilization of services, costs, quality measurements, use of various categories of drugs, (e.g., generic, single source, etc.) provider prescribing patterns and patient outcomes.

e. The carrier will be subject to independent audits to assure that quality, service, professional standards and other express commitments are being met.

f. The Carrier will make benefit payments to the participating providers or, in the case of services received from non-participating providers, the Carrier will make benefit payments to the enrollee or non-participating provider, as appropriate.

g. The Carrier will administer Drug Utilization Review (DUR) activities to review whether patients receive appropriate drug therapy as measured against generally accepted pharmaceutical practices. Such DUR incorporates concurrent and retrospective reviews. It also incorporates a voluntary drug formulary and a mandatory program to promote the use of generic prescription drugs, where appropriate. In addition, DUR will attempt to identify a variety of critical drug therapy problems such as, but not limited to:

- (1) Drug-disease conflicts;
- (2) Drug-drug interactions;
- (3) Age/gender prescription conflicts;
- (4) Over and under utilization;
- (5) Allergy alerts;
- (6) Therapeutic duplication; and
- (7) Early refills.

h. The Carrier will provide a comprehensive on-line, point-of-service claims processing system with an electronic telecommunication network that facilitates management of enrollee eligibility verification, formulary information, drug prescribing protocols, drug utilization review, pharmacy reimbursement and possibly expanded patient information, to make informed dispensed decisions.

i. The Carrier will conduct pharmacist profiling, and individual intensive education will be completed as necessary.

j. The Carrier will conduct physician profiling and will identify physicians who exhibit persistently inappropriate prescribing patterns across their practice. Such physicians will be the subject of individual intensive education efforts, as necessary.

k. The Carrier will prepare appropriate communications regarding the prescription drug coverage for enrollees, network pharmacies, and as necessary, for prescribing physicians.

l. The Carrier will ensure that quality assurance mechanisms will be administered to identify routinely inappropriate drug prescribing that could result in adverse medical outcomes, including hospitalization by incorporating components such as:

(1) A total quality management (TQM) philosophy;

(2) Rigorous pharmacy management and performance monitoring;

(3) Prescribing physician reeducation as necessary;

(4) Client specific program performance management;

(5) Patient medication compliance monitoring, and

(6) Outcomes assessment analyses.

H. Hearing Aid Coverage

1. Definitions

For the purposes of this subsection:

a. “*physician*” means a participating otologist or otolaryngologist who is board certified or eligible for certification in such specialty in compliance with standards established by the respective professional sanctioning body, who is a licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of such license, performs a medical examination of the ear and determines whether the patient has a loss of hearing acuity and whether the loss can be compensated for by a hearing aid;

b. “*audiologist*” means any participating person who (1) possesses a master’s or doctorate degree in audiology or speech pathology from an accredited university, (2) possesses a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association and (3) is qualified in the state in which the service is provided to conduct an audiometric examination and hearing aid evaluation test for the purposes of measuring hearing acuity and determining and prescribing the type of hearing aid that would best improve the enrollee’s loss of hearing acuity. A physician performing the foregoing services shall be deemed an audiologist for purposes of this subsection;

c. “*dealer*” means any participating person or organization that sells hearing aids prescribed by a physician or audiologist to improve hearing acuity in compliance with the laws or regulations governing such sales, if any, of the state in which the hearing aids are sold;

d. “*provider*” means a physician, audiologist or dealer;

e. “*participating*” means having a written agreement with the carrier pursuant to which services or supplies are provided under this subsection (if the carrier does not maintain agreements with such providers, “*participating*” shall mean any provider approved for reimbursement by the carrier);

f. “*hearing aid*” means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if necessary;

g. “*ear mold*” means a device of soft rubber, plastic or a non-allergenic material which may be vented or non-vented that individually is fitted to the external auditory canal and pinna of the enrollee;

h. “*audiometric examination*” means a procedure for measuring hearing acuity that includes tests relating to air conduction, bone conduction, speech reception threshold and speech discrimination;

i. “*hearing aid evaluation test*” means a series of subjective and objective tests by which a physician or audiologist determines which make and model of hearing aid will best compensate for the enrollee’s loss of hearing acuity and which make and model will therefore be prescribed, and shall include one visit by

the enrollee subsequent to obtaining the hearing aid for an evaluation of its performance and a determination of its conformity to the prescription;

j. “*dispensing fee*” means a fee predetermined by the carrier to be paid to a dealer for dispensing hearing aids, including the cost of providing ear molds, under this subsection;

k. “*acquisition cost*” means the actual cost to the dealer of the hearing aid.

2. Coverages

An enrollee is eligible for benefits for covered hearing aid expenses as described below:

a. **Audiometric Examinations:** The lesser of charges or the carrier allowed amount for audiometric examinations performed by a physician or audiologist, but only when performed in conjunction with the most recent medical examination of the ear by a physician.

b. **Hearing Aid Evaluation Test:** The lesser of the charges or the carrier allowed amount for hearing aid evaluation test performed by a physician or audiologist, which may include the trial and testing of various makes and models of hearing aids to determine which make and model will best compensate for the loss of hearing acuity but only when indicated by the most recent audiometric examination. For purposes of this subsection only, the carrier allowed amount is defined as \$169 (\$169 effective October 1, 2018). This amount shall be adjusted on October 1 of each year by the percentage increase as of the May levels in the United States Consumer Price Index for the immediately preceding twelve months. The result will be rounded to the nearest dollar.

c. Hearing Aids and Ear Molds: An allowance of up to \$2,200 every three years (3) for the acquisition cost and dispensing fee to purchase hearing aids and ear molds (as applicable), plus replacements, adjustments and repairs (as required). The hearing aids prescribed must be based upon the most recent audiometric examination and most recent hearing aid evaluation examination. The hearing aids dispensed by the dealer or audiologist must be the make and model prescribed by the physician or audiologist and must be certified as such by the physician or audiologist.

d. In order for the charges for services and supplies described in subsections a., b. and c. immediately above to be payable as hearing aid benefits under this subsection, for initial hearing aids, enrollees must obtain a medical examination of the ear by a physician. Such examination or such examination in conjunction with the audiometric examination must result in a determination that hearing aids would compensate for the loss of hearing acuity. For enrollees under the age of 18, a medical examination is required each time a hearing aid is covered.

3. Limitations

Frequency: Only one (1) audiometric examination, one (1) hearing aid evaluation test and one (1) \$2,200 allowance for hearing aids/molds will be provided for an individual enrollee in a three (3) year period.

4. Exclusions

Covered hearing aid expense does not include and no benefits are payable, under this Section III. H., for:

a. Audiometric examinations for any condition other than loss of hearing acuity;

- b.** Medical or surgical treatment;
- c.** Drugs or other medication;
- d.** Audiometric examinations, hearing aid evaluation tests and hearing aids provided under any applicable Workers Compensation law;
- e.** Audiometric examinations and hearing aid evaluation tests performed, and hearing aids ordered:
 - (1)** before the enrollee became eligible for coverage; or
 - (2)** after termination of the enrollee's coverage;
- f.** Hearing aids ordered while covered but delivered more than 60 days after termination of coverage;
- g.** Charges for audiometric examinations, hearing aid evaluation tests and hearing aids for which no charge is made to the enrollee or for which no charge would be made in the absence of hearing aid coverage;
- h.** Charges for audiometric examinations, hearing aid evaluation tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not recommended or approved by the audiologist or physician;
- i.** Charges for audiometric examinations, hearing aid evaluation tests and hearing aids that do not meet professionally accepted standards of practice, including charges for any such services or supplies that are experimental in nature;

j. Charges for audiometric examinations, hearing aid evaluation tests and hearing aids received as a result of ear disease, defect or injury due to an act of war, declared or undeclared;

k. Charges for audiometric examinations, hearing aid evaluation tests and hearing aids provided by any governmental agency that are obtained by the enrollee without cost by compliance with laws or regulations enacted by any federal, state, municipal or other governmental body;

l. Charges for any audiometric examinations, hearing aid evaluation tests and hearing aids to the extent benefits therefore 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;

m. Charges for the completion of any claim forms;

n. Charges incurred by persons enrolled in alternative plans.

I. Durable Medical Equipment and Prosthetic and Orthotic Appliances

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for the rental or purchase of durable medical equipment and the purchase of prosthetic and orthotic appliances only when the following conditions have been met:

a. Coverage is provided for the basic equipment or appliances plus medically necessary special features prescribed by the attending physician

and approved by the carrier or preferred provider organization (see App. A, II.A.).

b. The equipment or appliances must be prescribed by a physician and the prescription must include a description of the equipment and the reason for use or the diagnosis.

c. Coverage is provided for the purchase of durable medical equipment or prosthetic or orthotic appliances ordered on or after the effective date and prior to the termination date of the enrollee's coverage in this Program.

d. Coverage is provided for the rental charges for durable medical equipment for periods on or after the effective date and prior to the termination date of the enrollee's coverage in this Program.

2. Payment of Services

a. The carrier will make payment based on its allowed amount for rental or purchase of durable medical equipment when obtained from a provider other than a hospital or skilled nursing facility. Benefit payments for rental of durable medical equipment shall not exceed the purchase price of such equipment.

b. The carrier will make payment based on its allowed amount for external prostheses and orthotic appliances.

3. Coverages

a. Process for Updating Coverages

(1) A procedure has been established for the ongoing periodic update of the durable medical

equipment and prosthetic and orthotic appliance coverages.

(2) Written notification of changes in Medicare Part B durable medical equipment and prosthetic and orthotic appliance coverages, and other recommendations for coverage changes, will be provided to the Company by the Control Plan.

The notifications and recommendations shall include, but not be limited to, the following information:

(a) Quality of care, access and appropriate utilization concerns and proposed actions to resolve such concerns;

(b) Any item(s) being replaced by new item(s), and a plan for discontinuation of coverage for the replaced item(s); and

(c) Positive or negative impact on Program costs.

(3) The Company will implement Medicare Part B coverage changes and review and approve or disapprove other Control Plan recommendations. When a change is made, an effective date will be established.

(4) The Control Plan will advise appropriate carriers of any changes which are approved through this procedure, the effective dates, and any applicable administrative rules. The local carriers will advise providers.

b. Durable Medical Equipment

(1) Unless otherwise indicated below, the equipment must be an item of durable medical

equipment which meets Program standards including being approved for reimbursement under Medicare Part B or adopted in accordance with the process in subsection 3.a., above, and be appropriate for use in the home.

(2) Durable medical equipment is covered when used in a hospital or skilled nursing facility, or when used outside the hospital or skilled nursing facility and rented or purchased from such hospital or facility upon discharge.

(3) When the equipment is rented and the rental period extends beyond the expiration of the original prescription, the physician must recertify by another prescription that the equipment continues to be reasonable and medically necessary for the treatment of the illness or injury or to improve the functioning of a malformed body member. If the recertification is not submitted, coverage will cease on the date indicated on the original prescription for duration of need, or thirty (30) days after the date of death, whichever is earlier. Coverage will not be provided for rental charges in excess of the purchase price of the equipment.

(4) When the equipment is purchased, coverage is provided for repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance is not covered.

(5) The following equipment is covered, subject to any stated conditions and to the other Program standards, although not Medicare approved:

(a) neuromuscular stimulators, if prescribed by an orthopedic or physiatric specialist;

(b) positioning transportation chairs as

alternatives to traditional wheelchairs for children fourteen (14) years of age and under, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders or congenital abnormalities;

(c) electromagnetic bone growth stimulators, as an alternative to bone grafting in cases of severe physical trauma involving non-union of long bone fractures (in excess of 90 days from the date of fracture), or failed bone fusion;

(d) pressure gradient supports (also known as burn pressure garments) prescribed for circulatory insufficiency conditions to promote and restore normal fluid circulation in the extremity (up to four times annually for chronic conditions unless there is a change in physical conditions such as gain or loss of weight of the patient), and when prescribed to enhance healing and prevent scarring of burn patients;

(e) phototherapy (bilirubin) light with photometer, for patients under the age of one (1) having a diagnosis of hyperbilirubinemia;

(f) special features which, although not subject to review and approval under Medicare Part B, are necessary to adapt otherwise covered equipment for use by children;

(g) continuous passive motion device for use on elbow and shoulder after surgical treatment; and

(h) continuous glucose monitors for certain diabetic patients who meet Control Plan criteria.

(6) Pronged and standard canes must be purchased.

c. Prosthetic and Orthotic Appliances

(1) Unless otherwise indicated below, the appliance must be a prosthetic or orthotic device which meets Program standards including being approved for reimbursement under Medicare Part B or adopted in accordance with the process in subsection 3.a., above.

(a) The coverage for therapeutic shoes prescribed for diabetics not eligible for Medicare shall be limited to the diagnoses established by the Control Plan.

(b) The following items are covered, subject to any stated conditions and to the other provisions of the Program and this subsection, although not Medicare-approved:

(i) any style of orthopedic footwear, other than a basic oxford, when the shoes are an integral part of a covered brace;

(ii) all orthopedic shoe inserts, arch supports limited to one (1) pair per calendar year and diagnoses established by the Control Plan; and

(iii) wigs and appropriate related supplies (stand and tape) are covered for enrollees who are suffering hair loss from the effects of chemotherapy, radiation or other treatments for cancer. For the first purchase of a wig and necessary related supplies the maximum benefit will be \$200. Thereafter, a maximum annual benefit of up to \$125 will be provided for such purchases.

(2) Coverage is provided for appliances furnished by a fully accredited facility or, with carrier approval, by facilities conditionally accredited by the American Board for Certification in Orthotics and

Prosthetics, Inc. as a provider for the kind of device supplied. The following appliances may be provided by facilities not accredited by the American Board for Certification in Orthotics and Prosthetics: ocular prostheses; prescription lenses; pacemakers; ostomy sets and accessories; catheterization equipment and urinary sets; prefabricated custom fitted orthotic appliances; artificial ears, noses, and larynxes; external breast prostheses; wigs and related supplies and such other appliances as the carrier may determine.

(3) Coverage includes prosthetic appliances or devices which 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, as well as external prosthetic or orthotic appliances prescribed by a physician for use outside the hospital.

(4) Coverage for a prosthetic and orthotic appliance includes the replacement, repair, fitting and adjustments of the appliance.

(5) Coverage includes prescription lenses (eyeglasses or contact lenses) only following a cataract operation for any disease of the eye or to replace the organic lens missing because of the congenital absence, or when customarily used during convalescence from eye surgery.

4. Limitations and Exclusions

a. Durable medical equipment which is not covered includes, but is not limited to:

(1) deluxe equipment such as motor driven wheelchairs and beds, unless medically necessary for

the treatment of the enrollee's condition and required in order for such enrollee to be able to operate the equipment (for deluxe equipment or features which are not medically necessary for the treatment of the enrollee's condition and required in order for such enrollee to be able to operate the equipment, benefits are limited to the comparable cost of basic, standard equipment);

(2) items not medical in nature (which are primarily comfort and convenience items such as bedboards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms, air conditioners);

(3) physician's equipment (such as sphygmomanometers and stethoscopes);

(4) exercise and hygienic equipment: such as exercycles, Moore Wheel, bidet, toilet seats and bathtub seats;

(5) self-help devices not primarily medical in nature (such as sauna baths and elevators); and

(6) experimental or research equipment.

b. Coverage for prosthetic and orthotic appliances does not include:

(1) dental appliances; hearing aids; eyeglasses (except as provided in subsection 3.c.(5) above); or such non-rigid appliances and supplies as elastic stockings, garter belts, arch supports, corsets and corrective shoes unless the shoe is attached to a medically necessary brace or covered under subsections 3.c.(1)(a) and (b), above; or

(2) experimental or research devices.

J. Pre-Hospice and Hospice Coverage

1. Pre-Hospice Care

a. An enrollee is eligible for pre-hospice services by recommendation of a physician who certifies that the patient has been diagnosed with a terminal illness.

b. Coverage for pre-hospice services must meet program standards and consist of evaluation, consultation and education, and support services. Up to twenty-eight lifetime visits are available prior to admission to a hospice program.

c. Pre-hospice services are to be provided by an approved Hospice program but are not part of the Hospice benefit and do not count against the Hospice lifetime maximum.

d. Coverage for pre-hospice services allows continuation of curative treatment while the patient is considering enrollment in the Hospice program.

2. Hospice Coverage

Hospice coverage, as described below, addresses the needs of terminally ill patients who do not require the continuous level of care provided in a hospital or skilled nursing facility.

a. Definitions

For the purposes of this subsection:

(1) “*Bereavement counseling*” means services provided to the patient’s family (or other person caring for the patient at home) after the patient’s death.

(2) “*Care rendered in a nursing home facility with hospice support*” means care provided to patients who are medically stable but unable to return home because there is no primary care giver available to care for the patient at home, and the patient cannot self-administer the needed care.

(3) “*Respite care*” means short-term inpatient care provided only when necessary to give relief to family members or other persons caring for the patient at home.

b. Conditions of Hospice Benefit Payments

An enrollee is eligible for benefits for covered expenses incurred in a hospice program only if the following conditions have been met:

(1) The admission to the hospice program commences on or after the effective date and prior to the termination date of the enrollee’s coverage in this Program.

(2) The services are provided and billed by a hospice program which meets Program standards and is approved by the local carrier.

(3) The enrollee is admitted to the hospice program by order of a physician who certifies that the enrollee requires the type of care available through the hospice and that the enrollee has a life expectancy of twelve (12) months or less.

(4) The enrollee voluntarily elects to participate in the hospice program and agrees to accept the services provided by the hospice program as treatment of the terminal condition.

(5) The enrollee has benefit period days available under the hospice benefit period (see App. A, II.B.).

c. Hospice Coverages

(1) Benefits for hospice services are limited to a maximum aggregate lifetime benefit in accordance with Program standards.

(2) Upon admission to an approved hospice program, an enrollee is entitled to receive the following services when rendered as part of the treatment plan:

(i) nursing care provided by or under the supervision of a registered nurse,

(ii) medical social services provided by a social worker under the direction of a physician;

(iii) physician services;

(iv) counseling services provided to the patient, family members and/or other persons caring for the patient at home;

(v) general inpatient care provided in a hospice inpatient unit;

(vi) medical appliances and supplies;

(vii) physical, occupational and speech therapies;

(viii) continuous home care provided during periods of crisis as necessary to maintain the patient at home;

- (ix) respite care;
- (x) bereavement counseling;
- (xi) care rendered in a nursing home with hospice support; and
- (xii) home health aide services.

K. Case Management Program

1. The Case Management Program (CMP) is intended to provide high quality, cost-effective alternative treatment options for patients with catastrophic, chronic, and long-term treatment needs which may result in exhaustion of benefits or high costs. It focuses on those whose care could be maintained, improved or prolonged by more effective use of existing Program provisions or, in appropriate cases, through alternative treatment plans designed to cost no more than the treatment otherwise planned. CMP is not a method for approving new procedures or services not otherwise covered under the Informed Choice Plan.

2. The list of conditions used by the carriers for review for potential CMP involvement includes, but is not limited to, the following:

- a.** major head trauma;
- b.** spinal cord injury;
- c.** comatose;
- d.** multiple amputations;
- e.** traumatic and degenerative muscular/neurological disorders (e.g., muscular dystrophy, “Lou Gehrig’s Disease,” multiple sclerosis);

- f.** newborns with high risk complications;
- g.** births with multiple congenital anomalies;
- h.** cerebrovascular accident (stroke) requiring long-term rehabilitation;
- i.** severe burns;
- j.** Acquired Immune Deficiency Syndrome (AIDS);
- k.** selected blood abnormalities;
- l.** diagnoses involving long-term IV therapy (e.g., osteomyelitis, pericarditis, endocarditis);
- m.** severe rheumatoid arthritis;
- n.** selected osteoarthritis;
- o.** Crohn's disease; and
- p.** cases involving extended or repeated hospital stays, as well as cases having multiple admissions for the same diagnosis.

3. Once a patient's medical condition is identified by the carrier as having potential for case management, the case is reviewed confidentially, and an Alternative Benefit Plan may be developed by the carrier with the cooperation of the patient, family, and the physicians/providers.

4. If a decision is made to implement an Alternative Benefit Plan that incorporates services not otherwise covered under this Program, the remaining

days of inpatient care, determined in accordance with the attending physician's prognosis, are converted into a dollar pool against which all benefits paid while the patient is under the Alternative Benefit Plan are charged.

a. The total cost of Alternative Benefit Plans involving services not otherwise covered will be limited by the cost of treatment which would have occurred otherwise.

b. If the dollar pool is exhausted, the Alternative Benefit Plan ceases and the provisions of Appendix A, II.B. will apply with regard to renewal of a benefit period.

c. Participation in the CMP is voluntary, and the patient may withdraw from the Alternative Benefit Plan at any time. In such event, the remaining dollar pool is reconverted to equivalent hospital days to determine the patient's entitlement, if any, remaining in the benefit period.

d. Long Term Acute Care Hospitals (LTACH) will be recognized as eligible providers under CMP as long as all services have been reviewed and approved by the carrier through CMP prior to admission.

IV. Limitations and Exclusions

In addition to the limitations and exclusions appearing in other Sections of this Appendix, the following general limitations and exclusions apply to all Sections:

A. *Effective date:* For the purposes of this Section, effective date means the later of the effective date of this Program or the effective date of the enrollee's coverage under this Program. Benefits are not provided under this Program for:

1. services, treatment, or care provided to an enrollee prior to the effective date; or

2. hospital, skilled nursing facility, or home health care services for admissions which commenced prior to the effective date.

B. *Termination date:* Coverage is not provided for services provided after the date this Program or an enrollee's coverage under this Program is terminated except that the coverage continues for physician and hospital, or residential substance abuse facility services for continuous predetermined and approved (see App. A, II.A. and Appendix B, II.B.) inpatient admissions which commenced prior to the termination date of such coverage.

C. *Blood:* Coverage is not provided for the preservation and storage of body components for future use when not required by, and performed in conjunction with, another covered service.

D. *Private duty nursing services:* Coverage does not include services of private duty nurses. Private duty nursing means nursing care which is privately contracted by, or on behalf of, an enrollee with a nurse, or agency, independent of this Program.

E. *Room accommodations:* If accommodations more expensive than those specified in Section III.A. are used for any reason, the carrier will not pay the difference between the charges for the more expensive accommodations and those for the covered accommodations. If, for any reason, the enrollee occupies accommodations less expensive than those covered by this Appendix, the enrollee is not entitled to payment of the difference in charges.

F. *Dental services:* Coverage does not include dental services except as specifically provided for in this Appendix.

G. *Chemotherapy:* Coverage does not include chemotherapy services except as specifically provided for in this Appendix.

H. *Medical necessity:* Coverage does not include services, care, treatment, or supplies which are not medically necessary according to accepted standards of medical practice for the treatment of any condition, injury, disease, or pregnancy, except as specifically provided for in this Appendix (e.g., voluntary sterilizations).

I. *Research or experimental services:* Coverage does not include care, services, supplies, or devices which are experimental or research in nature.

J. *Personal or convenience items:* Coverage does not include care, services, supplies, or devices which are personal or convenience items.

K. *Services not related to specific diagnosed illness or injury:* Coverage does not include services for premarital examinations; pre-employment examinations; or for routine or periodic physical examinations unrelated to the existence of a previously diagnosed specific condition, disease, illness, or injury, except as specifically provided for in this Appendix.

L. *Unreasonable charges:* Coverage does not include any charges to the extent such charges are determined by the carrier to be unreasonable.

M. *Employer related services:* Coverage does not include services related to any condition, disease, ailment, or injury arising out of or in the course of employment and for which the employer furnishes, pays for, or provides reimbursement under the provisions of any law of the United States or any state or political subdivision thereof, or for which the employer makes a settlement payment. Coverage does not include services rendered through a medical clinic or other similar facility provided or maintained by an employer.

N. *Services available without cost:* Coverage does not include services for which a charge would not have been made if no coverage existed; services for which the enrollee is not legally obligated to pay; services which the enrollee received or, upon application, could receive without cost under the laws or regulations of the United States of America, Dominion of Canada, any other country, or any state or political subdivision thereof.

O. *Services available through other programs:* Coverage does not include any service to the extent the benefits are payable:

1. Under any group health care contract under the coordination of benefits provision of this Program;
2. Under Medicare, if the enrollee was or would have been eligible for Medicare benefits at the time of service had the enrollee enrolled in Medicare (see App. A, II.E.); or
3. Under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision except where by law this Program is made primary.

P. *Services provided by family members or relatives:*
Coverage does not include services provided to the enrollee by a person related to the enrollee by blood or marriage.

Q. *Services related to corrective eye surgery:*
Coverage under this Appendix does not include any services, supplies or charges related to corrective eye surgery, as defined in Appendix D, III. K. of this Program. See Appendix D, IV. C. for Program coverage provisions for such surgery.

APPENDIX B

MENTAL HEALTH AND SUBSTANCE ABUSE

The provisions of this Appendix B apply to enrollees of the TCN option.

I. Definitions

To the extent they are not in conflict with the following, definitions in Appendix A are incorporated herein by reference. For purposes of this Appendix:

A. “*approved mental health or substance abuse treatment program and/or provider*” means an inpatient or outpatient program and/or provider which/who provides medical and other services to enrollees for a mental health or substance abuse condition, meets all state licensure and approval requirements, and has entered into an agreement with the coverage carrier to provide services as specified in this Appendix;

B. “*assessment*” means

1. determination by an assessment coordinator of the nature of the enrollee’s condition (mental health and/or substance abuse), the need for treatment, the type of treatment required and referral to the most appropriate level of care; and,

2. for the substance abuse patient, the development of a continuing care treatment plan by the enrollee, the assessment coordinator, and the attending physician, if appropriate;

C. “*assessment coordinator*” means a qualified employee of a central diagnostic and referral agency

(CDR) which has been selected and approved to provide assessment services. Assessment coordinators must meet Program standards for selection;

D. “*central diagnostic and referral agency*” or “CDR” means an approved agency which employs assessment coordinators designated to:

1. make face-to-face assessments for the development of substance abuse continuing care treatment plans;

2. make determinations regarding whether the patient’s condition requires mental health and/or substance abuse treatment;

3. make referrals to panel providers;

4. provide short-term counseling (up to 2 visits);
and

5. perform aftercare planning and follow-up.

In addition, the CDR may provide up to 3 short-term counseling sessions for employees, and communicate with Work/Family Representatives about assessment and referral activities relating to an employee, where appropriate and when authorized by the employee. The CDR will supply necessary information to the carrier about panel provider performance and selection and other utilization data and statistics as required, including evaluation using designated performance data of panel providers with whom the carrier contracts;

E. “*central review organization*” or “CRO” means a national organization which has been designated to provide the following functions:

1. confirm eligibility of the patient for mental health and/or substance abuse coverage under the Program;
2. authorize and approve mental health treatment, substance abuse treatment, and outpatient psychological testing;
3. monitor CDR performance;
4. exercise managed care protocols, with CDR assistance when appropriate, for those enrollees who require both mental health and substance abuse outpatient visits; and
5. evaluate panel providers and make contracting recommendations to the carrier, using designated performance standards;

F. “*clinical nurse specialist*” means a person who meets all of the following criteria: possesses a Master of Arts (MA), Master of Science (MS) or Master of Science in Nursing (MSN) degree from an accredited school of nursing; the Master’s degree must be in psychiatric nursing or the individual must have 2,000 hours of clinical supervision post-Masters degree; must have a minimum of five years post- Masters degree clinical experience in the field of psychiatric mental health nursing at least two years of which were supervised by a Masters level psychiatric nurse (or the equivalent); possesses a license as a registered nurse in the jurisdiction in which the practice is to occur; be eligible for listing in an American Nursing Association Register of Certified Nurses in Advanced Practice as a clinical specialist in adult psychiatric mental health nursing or child/adolescent psychiatric nursing; and participates as a panel provider.

G. “*continuing care treatment plan*” means a document completed for substance abuse patients by an assessment coordinator at the conclusion of the assessment process. The continuing care treatment plan includes the recommended provider(s), and the type(s) and duration of treatment, and may be modified by the provider and the assessment coordinator in consultation during the course of treatment;

H. “*detoxification*” means inpatient treatment for the physiologic stabilization of an enrollee who is undergoing acute withdrawal from an intoxicating substance. To be covered under this Program, such treatment must be provided by, or under the supervision of, a physician and through a facility approved to provide such care;

I. “*detoxification facility*” means a hospital or residential treatment facility which is a provider of detoxification services. Such facilities may offer substance abuse rehabilitation treatment subsequent to detoxifying an enrollee;

J. “*halfway house treatment*” means treatment provided under a semi-residential living arrangement to a substance abuse patient who requires a more structured living environment than outpatient treatment or partial hospitalization treatment would provide, but who does not require full-time residential treatment and care. It provides a controlled environment during the hours of the day the enrollee is not undergoing treatment or is not engaged in specific constructive activity (e.g., working, attending school);

K. “*inpatient care*” means treatment in:

1. a hospital;
2. a detoxification facility; or
3. a residential care facility;

L. “*mental disorder*” means any mental, emotional, or personality disorder classified as a mental disorder in the most recent edition of the “International Classification of Diseases, 9th Revision, Clinical Modification”, including classification 305.1, but excluding alcohol and drug abuse as classified in categories 303.0 through 305.8;

M. “*outpatient facility*” means an administratively distinct governmental, other public, private, or independent unit or part of such unit that provides outpatient mental health or substance abuse services. The term includes centers for the care of adults or children such as hospitals, clinics, and partial hospitalization treatment centers. For mental health services, the definition includes Community Mental Health Centers as defined in the Federal Community Mental Health Centers Act of 1963, as amended;

N. “*outpatient treatment*” or “*visit*” (including intensive outpatient treatment) means a therapy session provided in an outpatient mental health or substance abuse treatment facility or by an individual mental health or substance abuse provider. All sessions between an individual patient and a provider in a single day, with a total duration of four (4) hours or less, are considered to be a single treatment or visit. If outpatient sessions with all providers in a given day total more than four (4) hours, such treatment shall be considered partial hospitalization;

O. “*panel provider*” or “*network provider*” means a mental health or substance abuse provider who has been selected and has agreed to provide services in accordance with the terms of participation established by the Program and has executed an agreement with the carrier;

P. “*partial hospitalization treatment*” means a semi-residential level of care for patients with mental health or substance abuse disorders who require coordinated, intensive, comprehensive and multidisciplinary treatment in a structured setting, but less than full-time hospitalization. The patient undergoes therapy for more than four (4) hours a day, and may receive additional services (e.g., meals, bed, recreation);

Q. “*psychiatrist*” means a physician who is board eligible or board certified in psychiatry and licensed to practice medicine at the time and place services are rendered or performed;

R. “*psychologist*” means a person who possesses a doctor of philosophy (Ph.D.), doctor of education (Ed.D.), doctor of mental health (DMH.), or doctor of psychology (PsyD.) degree from a regionally accredited university, has a minimum of five years of post-doctoral clinical experience (at least two of which were supervised by a licensed clinical psychologist or by a board-qualified psychiatrist), possesses a valid license for the independent practice of psychology at the highest level recognized by the state in which practice is to occur, is eligible for listing in the National Register of Health Care Providers in Psychology, and participates as a panel provider;

S. “*registration*” means contact by the provider with the CRO to inform the agency that the enrollee is commencing a course of mental health or substance abuse treatment, to confirm eligibility under the Program, and to obtain any necessary approvals or authorizations;

T. “*residential care facility*” means an approved inpatient facility which operates twenty-four (24) hours a day, seven (7) days a week for the provision of residential mental health and/or substance abuse treatment;

U. “*social worker*” means a person who possesses a master in social work (MSW), master of science in social work (MSSW), or doctor of social work (DSW) from a graduate school of social work accredited by the Council on Social Work Education, has a minimum of five years of post-masters or post- doctoral degree clinical social work experience (at least two of which were supervised by a licensed clinical social worker), possesses a valid license or certificate for the independent practice of social work at the highest level recognized by the state in which practice is to occur (e.g., Licensed Clinical Social Worker (LCSW)), is eligible for listing in the National Association of Social Work Register of Clinical Social Workers and/or the National Register of Mental Health Care Providers in Social Work, and participates as a panel provider; and

V. “*substance abuse*” means alcohol or drug dependence as classified in categories 303.0 through 305.8 (except 305.1) of the most current edition of the “International Classification of Diseases, 9th Revision, Clinical Modification.”

II. Terms and Conditions of Coverage

A. Conditions of Benefit Payment

An enrollee is eligible for benefits for covered expenses incurred during an approved course of treatment only if the following conditions are met:

1. Services must be provided on or after the enrollee's effective date of coverage under the Program and this Appendix.

2. Benefits must be available within the benefit period (see II.B., below).

3. a. In order to be covered in full under the Program, all covered services rendered in the care and treatment of mental health and substance abuse related disorders must be delivered by panel providers, except in the case of emergency which is subject to the provisions of Section IV.B.1. of this Appendix. The panel may be comprised of the following types of facilities and providers:

- (1) Hospitals
- (2) Outpatient facilities
- (3) Detoxification facilities
- (4) Residential care facilities
- (5) Partial hospitalization facilities
- (6) Halfway houses
- (7) Skilled nursing facilities

- (8) Psychiatrists
- (9) Psychologists
- (10) Social workers
- (11) Clinical nurse specialists
- (12) Outpatient Clinics

b. In addition, if due to the unavailability of specialized services, the enrollee needs referral to a non-panel provider, then, in such cases only, non-panel providers will be covered in full subject to App. B,II.B.4.a. and b., provided the enrollee is referred by the CRO or referred by a panel provider and the services are authorized, in advance, by the CRO.

c. Services provided in accordance with App. B, IV.B.3. are covered in full.

4. Benefits for outpatient treatment rendered by a clinical nurse specialist, social worker, or psychologist as an independent practitioner are available only if such practitioner participates as a panel provider.

5. The enrollee can be assessed by an assessment coordinator from a designated CDR for residential and/or halfway house substance abuse treatment. If such coordinator makes a determination of substance abuse and the assessment specifies a level of care which includes residential or halfway house treatment, such treatment will be covered subject to other Program provisions.

6. Detoxification admissions must be reported to the CRO or CDR within twenty-four (24) hours of admission. In such cases, the CRO can notify the

CDR assigned to that location. The CDR's assessment coordinator can contact the enrollee during or after the detoxification and develop a plan for treatment subsequent to detoxification (continuing care treatment plan). Detoxification confinements longer than three (3) days must be approved by the CDR or CRO.

7. Mental health inpatient services and admissions must be authorized by the CRO within twenty-four (24) hours of admission.

8. Partial hospitalization for mental health and substance abuse treatment must be registered with the CRO or CDR, if applicable.

9. Admission to a skilled nursing facility must be for the treatment of a mental health condition and must be authorized by the CRO.

10. Outpatient treatment services by panel and non-panel providers will be expected to comply with the managed care review and authorization requirements for any extended outpatient care services or for treatment for select diagnostic conditions as determined by the CRO or CDR, if applicable.

11. Benefits are payable subject to the provisions and limitations of the Program, regardless of the treatment plan developed through assessment.

12. Benefits payable under this Appendix for an enrollee eligible for Medicare shall be paid in accordance with the terms and conditions pertaining to Medicare as specified in Appendix A, Section II.E.

B. Benefit Period

1. a. An enrollee is eligible for a maximum of three hundred sixty-five (365) days of covered inpatient mental health care within the benefit period set forth in Appendix A, II.B.1.

b. An enrollee is eligible for a maximum of three hundred sixty-five (365) days of covered inpatient substance abuse care including detoxification within the benefit period set forth in Appendix A, II.B.1.

c. Each day of care utilized for inpatient substance abuse treatment is charged against the unused portion of the three hundred sixty-five (365) day inpatient mental health benefit period. Likewise, each day of inpatient mental health care is charged against the unused portion of the three hundred sixty-five (365) day inpatient substance abuse treatment period.

2. a. An enrollee is eligible for a maximum of seven hundred thirty (730) days of care in a partial hospitalization treatment facility within the benefit period set forth in Appendix A, II.B.1.

b. Each day of inpatient care for mental health or substance abuse treatment within the benefit period reduces by two (2) the number of days of care available for mental health or substance abuse partial hospitalization treatment. Each two (2) days of partial hospitalization treatment reduces by one (1) the number of days of care available for inpatient care.

3. a. An enrollee is eligible for a maximum of seven hundred thirty (730) days of mental health care in an approved skilled nursing facility within the benefit period set forth in Appendix A, II.B.1.

b. Each day of inpatient care for mental health treatment within the benefit period reduces by two (2) the number of available days for skilled nursing facility care. Each two (2) days of medical care for the treatment of mental disorders in a skilled nursing facility reduces by one (1) the number of days of inpatient medical care available for the treatment of mental health related disorders in a hospital.

4. a. An enrollee is eligible for the following outpatient mental health visits with a panel provider, or to a non-panel provider with advance referral: visits 1- 20 covered at 100%, visits 21-35 covered at 75% (with a maximum member cost of \$25 per visit), and visits 36 and over are covered with a \$25 co-payment per visit for both facility and professional services per calendar year.

b. An enrollee is eligible for the following outpatient substance abuse visits with a panel provider, or to a non-panel provider with advance referral: visits 1-35 covered at 100% and visits 36 and over are covered with a \$25 co-payment per visit for both facility and professional services per calendar year.

c. When an enrollee requires mental health and/or substance abuse outpatient treatment, the CRO and/or CDR (where appropriate) can exercise managed care protocols after a total of six (6) outpatient visits and can monitor the treatment plan(s) to assure appropriate coordinated care.

d. Anorexia Nervosa, Bulimia and other conditions covered by App. B. which are appropriate for case management, may be case managed by the CRO utilizing the case management procedures described in Appendix A, III.K. with any alternative benefit plan being limited to the dollar pool created using the three hundred sixty-five (365)-day inpatient benefit described in this section.

e. Outpatient psychological testing is not considered “treatment” and is not charged against the outpatient visits in Section II.B.4.a. and b.

f. Each visit by one or more members of an enrollee’s family for family counseling counts as one (1) visit, as defined in Section II.B.4.a and b.

5. An enrollee shall be eligible for a lifetime maximum of ninety (90) days of substance abuse treatment in a panel halfway house.

6. A new benefit period begins only when the enrollee has been out of care (as described below) for a continuous period of sixty (60) days. Accordingly, there must be a lapse of at least sixty (60) consecutive days between the date of the enrollee’s last discharge from any hospital, skilled nursing facility, residential care facility or any other facility to which the 60-day benefit renewal period of this Appendix and Appendix A apply (see Appendix A, II.B.4. for example), and the date of the next admission, irrespective of the reason for the last admission and irrespective of whether or not benefits are paid as a consequence of such admission. Further, if subsequent to such discharge, the enrollee is a patient in a psychiatric or substance abuse partial hospitalization program, a substance abuse halfway house, a hospice program or is receiving home health care visits, the 60-day renewal period is broken, whether or not benefits are paid as a result of receipt of such services.

III. Coverages

A. Inpatient Care (Mental Health and Substance Abuse)

1. Inpatient mental health and substance abuse care is subject to the benefit period set forth in App. B, II.B.1.

2. Inpatient services by non-panel providers are subject to the cost-share provisions of Article II, 4(b)(9), including the 90% limitation on payment for services provided by non-panel providers and the annual out-of-pocket maximum of \$250 (individual)/\$500 (family) which is to be shared between medical and mental health/substance abuse services.

3. Coverage includes the following inpatient services when provided and billed by the facility:

a. semiprivate room, including general nursing services, meals and special diets;

b. laboratory and pathology examinations related to the treatment received in the facility;

c. drugs, biologicals, solutions and supplies related to the treatment received and used while the enrollee is in the facility;

d. supplies and use of equipment required in the care and treatment of the enrollee's condition;

e. professional and ancillary services, including those of other trained staff, necessary for patient care and treatment, including diagnostic examinations;

f. individual and group therapy;

g. counseling for family members;

h. electroshock therapy for a mental health patient, when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy;

i. supplies and use of equipment required for detoxification or rehabilitation of substance abuse patients; and

j. psychological testing administered by a panel psychologist when medically indicated and when directly related to the organic medical or functional condition or when it has an integral role in rehabilitative or psychiatric treatment programs.

4. Coverage for medical care for the treatment of mental disorders is limited to (i) individual psychotherapeutic treatment, (ii) family counseling for the enrollee's family, (iii) group psychotherapeutic treatment, (iv) psychological testing when prescribed or performed by a physician, and (v) electroshock therapy and anesthesia for electroshock therapy.

B. Skilled Nursing Facility Care (Mental Health Only)

1. Mental health care in a skilled nursing facility is subject to the benefit period set forth in App. B, II.B.3.

2. Coverage includes services as described in A.3., above, and medical care. Medical care in a skilled nursing facility is limited to a maximum of two (2) physician visits per week.

C. Halfway House Care (Substance Abuse Only)

1. Substance abuse care in a halfway house is subject to the benefit period set forth in App. B, II.B.5.

2. Coverage includes the following halfway house services when provided and billed by the facility:

a. bed and board;

- b.** intake evaluation;
- c.** up to one (1) routine drug screen per week;
- d.** individual and group therapy and or counseling; and
- e.** counseling for family members.

D. Partial Hospitalization (Mental Health and Substance Abuse)

1. Mental health and substance abuse care in partial hospitalization treatment facilities is subject to the benefit period set forth in App. B, II.B.2.

2. Inpatient services by non-panel providers are subject to the cost-share provisions of Article II, 4(b)(9), including the 90% limitation on payment for services provided by non-panel providers and the annual out-of-pocket maximum of \$250 (individual)/\$500 (family) which is to be shared between medical and mental health/substance abuse services.

3. Coverage for treatment in a partial hospitalization treatment facility includes the following services when, provided and billed by the facility:

- a.** laboratory examinations related to the treatment received in the facility;
- b.** prescribed drugs, biologicals, solutions and supplies related to the treatment received, including, for substance abuse, drugs to be taken home;

c. supplies and use of equipment required in the care of the enrollee's condition;

d. professional and ancillary services including those of other trained staff, necessary for the treatment of ambulatory enrollees, including diagnostic examinations;

e. individual and group therapy;

f. psychological testing;

g. counseling for family members;

h. electroshock therapy for a mental health patient when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy; and

i. an enrollee admitted to partial hospitalization treatment also is entitled to a semiprivate room, general nursing services, meals and special diets.

E. Outpatient Care (Mental Health and Substance Abuse)

1. Outpatient mental health and substance abuse treatment is subject to the benefit periods set forth in App. B, II.B.4.a. and b.

2. Covered outpatient mental health and substance abuse treatment includes the following:

a. Services provided and billed by facilities.

(1) professional and other staff and ancillary services made available by facilities to ambulatory patients;

(2) prescribed drugs and medications dispensed by a facility in connection with treatment received at the facility; and

(3) electroshock therapy for a mental health patient, when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy.

b. Services provided and billed by facilities or professional providers.

(1) Individual psychotherapeutic treatments of less than twenty (20) minutes when provided in an outpatient mental health facility approved by the carrier.

(2) Individual psychotherapeutic treatments of a duration of twenty (20) minutes or more (all sessions with a given provider on a single day, with a total duration of four (4) hours or less, shall constitute a single "visit" and be reimbursed as a single unit of service).

(a) Benefits will be paid as set forth in App. B, II.B.4.a. for outpatient mental health services at 100% of the panel reimbursement amount for visits 1-20, 75% for visits 21-35 (with a maximum enrollee cost of \$25 per visit), and visits 36 and over are subject to a \$25 co-payment per visit per calendar year when provided by panel providers, or a non-panel provider with advance referral. Services rendered by non-panel

providers as provided in App. B, II.A.3.b. and in App. B, IV.B.3. shall be covered in full. Otherwise, when outpatient mental health services are received from a non-panel provider without referral, such services must be rendered by physicians, and will be reimbursed at 50% of the amount payable to panel providers for comparable services. Such reimbursement will be made only to the primary enrollee.

(b) Benefits will be paid as set forth in App. B, II.B.4.b. for individual outpatient substance abuse treatment at 100% of the panel reimbursement amount for visits 1-35 and visits 36 and over are subject to a \$25 co-payment per visit per calendar year when provided by panel providers, or to a non-panel provider with advance referral. No benefits are payable for treatment by non-panel providers, except when services are rendered by non-panel providers as provided in App. B, II.A.3.b. in which case such treatment shall be covered in full.

(3) Group mental health and substance abuse treatment is covered subject to the payment provisions in subsections (a) or (b) above.

(4) Family counseling to members of the patient's family is covered subject to the payment provisions in subsections (a) or (b) above.

3. Outpatient psychological testing is covered only when preauthorized by the CRO and performed by a panel provider. Such testing is not considered treatment and therefore is not subject to the benefit period maximum.

4. Arrangements with the CDRs:

a. For inpatient substance abuse care, assessments, referrals and continuing care treatment follow-up do not reduce the enrollee's outpatient visit entitlement; and

b. voluntary utilization of the CDR for either inpatient or outpatient mental health or substance abuse assessment and referral, does not count as an outpatient visit.

IV. Limitations and Exclusions

A. Panel providers are required to contact the CRO to verify eligibility and receive prior authorization of all non-emergency inpatient, partial hospitalization, residential treatment, nursing home and half-way house mental health and substance abuse services.

B. Coverage will be limited to the following when rendered by or through non-panel providers:

1. Emergency services. Providers must contact the CRO or CDR, if applicable, within twenty-four (24) hours of the inpatient admission, detoxification or outpatient treatment for authorization of such services.

2. Non-emergency services. Benefits for inpatient mental health or substance abuse services provided by non-panel providers without referral by a panel provider are subject to any non-panel payment limitations and out-of-pocket maximum provisions as described in Section III.A.2 of this Appendix.

3. Outpatient services.

a. Services provided by non-panel physicians (e.g., internists or general practitioners) must be registered with the CRO after the first visit and are limited to a maximum of one (1) visit.

b. Coverage for substance abuse treatment does not include services provided by non-panel providers except for emergency detoxification.

C. Coverage is not available for services for treatment of mental disorders which, according to generally accepted medical standards, are not amenable to favorable modification, except that coverage is available for the period necessary to determine that the disorder is not amenable to favorable modification, or for the period necessary for the evaluation and diagnosis of mental deficiency or retardation.

D. Coverage for substance abuse treatment does not include professional services such as dispensing methadone, testing urine specimens, or performing physical or x-ray examinations or other diagnostic procedures unless therapy, counseling or psychological testing are provided on the same day.

E. Coverage does not include family counseling which is rendered by a provider other than the provider for the family member in the course of treatment. Furthermore, reimbursement will be provided only for services rendered to enrollees covered under the General Motors Health Care Program.

F. Coverage does not include diversional therapy.

G. Coverage does not include psychological testing if used as part of, or in connection with, vocational guidance, training or counseling.

H. General Limitations and Exclusions under Section IV. and subsections II.C., E., G., and H. of the Terms and Conditions of Appendix A are equally applicable under this Appendix.

APPENDIX C DENTAL COVERAGE

I. Enrollment Classifications

Dental coverage for a primary enrollee shall include coverage for secondary enrollees as defined in the Program.

II. Description of Benefits

Dental benefits will be payable, subject to the conditions herein, if an enrollee incurs a covered dental expense.

III. Covered Dental Expenses

Covered dental expenses are the usual charges of a dentist which an enrollee is required to pay for services and supplies which are necessary for treatment of a dental condition, but only to the extent that such charges are reasonable and customary charges, as herein defined, for services and supplies customarily employed for treatment of that condition, and only if rendered in accordance with accepted standards of dental practice. Such expenses shall be only those incurred in connection with the following dental services which are performed, except as otherwise provided in Section VII. B., by a licensed dentist and which are received while coverage is in force.

A. The following covered dental expenses shall be paid at 100 percent of the carrier's allowed amount:

1. Routine oral examinations and prophylaxes (scaling and cleaning of teeth), but not more than twice each in any calendar year. Three cleanings per calendar year will be allowed if there is a documented history of periodontal disease. Four cleanings per calendar year

will be covered for two full calendar years following periodontal surgery.

2. One topical application of fluoride provided that such treatment is only for enrollees under 15 years of age, unless a specific dental condition makes such treatment necessary.

3. 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 cancer diagnosis and thereafter once with each subsequent recurrence of cancer, as medically necessary.

4. One Oral Exfoliative Cytology (brush biopsy) will be covered per calendar year for enrollees presenting with an un-resolving oral lesion/ulceration, or an enrollee with an oral lesion/ulceration having a history of behaviors that places the enrollee at risk for oral cancer. Covered services will include the collection of the biopsy specimen, and its laboratory interpretation.

5. Space maintainers that replace prematurely lost teeth for children under 19 years of age.

6. Emergency palliative treatment.

B. The following covered dental expenses shall be paid at 90 percent of the carrier's allowed amount:

1. Dental x-rays, including:

a. full mouth x-rays, once in any period of five (5) consecutive calendar years.

b. supplementary bitewing x-rays once every calendar year for enrollees age 14 and younger; and once every two years for enrollees age 15 and older, and

c. such other dental x-rays, including but not limited to those specified in a. and b. above, as are required in connection with the diagnosis of a specific condition requiring treatment.

2. Extractions.

3. Oral surgery.

4. Amalgam, synthetic porcelain, resin-based composite, and other American Dental Association (ADA)-approved direct restorative materials that meet Program standards and are used to restore diseased or accidentally injured teeth.

5. General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery.

6. Treatment of periodontal and other diseases of the gums and tissues of the mouth.

7. Endodontic treatment, including root canal therapy.

8. Injection of antibiotic drugs by the attending dentist.

9. Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; or relining or rebasing of dentures more than six (6) months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of three (3) consecutive calendar years.

10. Initial installation of inlays, onlays, gold fillings, or crown restorations to restore diseased or accidentally injured teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, synthetic porcelain, resin-based composite or other American Dental Association (ADA)-approved materials that meet Program standards and are used for direct filling restoration.

11. 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.

12. Cosmetic bonding of eight (8) front teeth for children 8 through 19 years of age if required because of severe tetracycline staining, severe fluorosis, hereditary opalescent dentin, or amelogenesis imperfecta, but not more frequently than once in any period of three (3) consecutive calendar years.

13. An occlusal guard (maxillary or mandibular) is a covered supply only for the palliative treatment of bruxism and/or acute pain of the muscles of mastication. The benefit is payable for one occlusal guard in a five-year period.

C. The following covered dental expenses shall be paid at 50 percent of the carrier's allowed amount:

1. Initial installation of fixed bridgework (including inlays and crowns as abutments).

2. Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six (6) month period following installation).

3. Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

a. the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;

b. the existing denture or bridgework cannot be made serviceable and, if it was installed under this dental coverage, at least five (5) years have elapsed prior to its 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 twelve (12) months from the date of initial installation of the immediate temporary denture.

Normally, dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a covered dental expense.

4. Orthodontic procedures and treatment (including related oral examinations) consisting of surgical therapy, appliance therapy, and functional/myofunctional therapy (when provided by a dentist in conjunction with appliance therapy) for enrollees under 19 years of age, provided, however, that benefits will be paid after attainment of age 19 for continuous treatment which began prior to such age.

5. The placement of an endosteal single tooth implant abutment, and crown, including any supportive services with the exception of IV sedation and/or general anesthesia. Coverage does not include bone grafts or specialized implant surgical techniques.

IV. Maximum Benefit For Other Than Accidental Dental Injury

The maximum benefit payable for all covered dental expenses incurred during a calendar year commencing January 1 and ending the following December 31 (except for services described in Section III. C.4. above and in Section X below) shall be \$1,850 for each enrollee.

For covered dental expenses in connection with orthodontics including related oral examinations, described in Section III. C.4. above, the maximum benefit payable shall be \$2,200 during the lifetime of each enrollee, with a maximum of \$2,000 applicable to covered dental expenses for services provided prior to January 1, 2008.

V. Pre-Determination of Benefits

If a course of treatment can reasonably be expected to involve covered dental expenses of \$200 or more, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the carrier prior to the commencement of the course of treatment.

The carrier will notify the enrollee and the dentist of the benefits certified as payable based upon such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services, or courses of treatment that may be performed for the dental condition concerned in order to accomplish the desired result.

The amount included as certified dental expenses will be the appropriate amount as provided in Sections III. and IV., determined in accordance with the limitations set forth in Section VI.

If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the carrier reserves the right to make a determination of benefits payable taking into account alternate procedures, services, or courses of treatment, based on accepted standards of dental practice. To the extent verification of covered dental expenses cannot reasonably be made by the carrier, the benefits for the course of treatment may be for a lesser amount than would otherwise have been payable.

This pre-determination requirement will not apply to courses of treatment under \$200 or to emergency treatment, routine oral examinations, x-rays, prophylaxes, and fluoride treatments.

VI. Limitations

A. Restorative

1. Gold, Baked Porcelain Restorations, Crowns and Jackets

If a tooth can be restored with a material such as amalgam, payment of the applicable percentage of the charge for that procedure will be made toward the charge for another type of restoration selected by the enrollee and the dentist. The balance of the treatment charge remains the responsibility of the enrollee.

2. Reconstruction

Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth.

Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and their cost remains the responsibility of the enrollee.

B. Prosthodontics

1. Partial Dentures

If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision appliance that enrollee and dentist may choose to use, and the balance of the cost remains the responsibility of the enrollee.

2. Complete Dentures

If, in the provision of complete denture services, the enrollee and dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment and the balance of the cost remains the responsibility of the enrollee.

3. Replacement of Existing Dentures

Replacement of an existing denture will be a covered dental expense only if the existing denture is unserviceable and cannot be made serviceable. Payment

based on the applicable percentage will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a covered dental expense only if at least five (5) years have elapsed since the date of the initial installation of that appliance under this dental coverage, except as provided in Section III. C.3. above.

C. Orthodontics

1. 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.

2. The benefit payment for orthodontic services shall be only for months that coverage is in force.

VII. Exclusions

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

A. charges for services for which benefits are provided under other health care coverages;

B. 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;

C. charges for veneers or similar properties of crowns and pontics placed on, or replacing teeth, other than the eight (8) upper and lower anterior teeth;

D. charges for services or supplies that are cosmetic in nature (except as provided in Section III.B.12.), including charges for personalization or characterization dentures;

E. 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;

F. charges for the replacement of a lost, missing, or stolen prosthetic device;

G. charges for failure to keep a scheduled visit with the dentist;

H. charges for replacement or repair of an orthodontic appliance;

I. charges for services or supplies which are compensable under a Workers Compensation or Employer's Liability Law;

J. charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the enrollee's employer;

K. 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;

L. 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;

M. 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;

N. charges for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;

O. 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;

P. charges for any duplicate prosthetic device or any other duplicate appliance;

Q. 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;

R. charges for the completion of any insurance forms;

S. charges for sealants and for oral hygiene and dietary instruction;

T. charges for a plaque control program; or

U. charges for services or supplies related to periodontal splinting.

VIII. Proof of Loss

The carrier reserves the right at its discretion to accept, or to require verification of, any alleged fact or assertion pertaining to any claim for dental benefits. As part of the basis for determining benefits payable, the carrier may require x-rays and other appropriate diagnostic and evaluative materials.

IX. Definitions

As used in this Appendix, the terms identified below have the meanings stated.

A. The term “*dentist*” means a legally licensed dentist practicing within the scope of such dentist’s license. As used herein, the term “dentist” also includes a legally licensed physician authorized by license to perform the particular dental services such physician has rendered.

B. The term “*area*” means a metropolitan area, a county or such greater area as is necessary to obtain a representative cross-section of dentists rendering such services or furnishing such supplies.

C. The term “*course of treatment*” means a planned program of one or more services or supplies, whether rendered by one or more dentists, for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

D. The term “*orthodontic treatment*” means preventive and corrective treatment of all those dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as a result of accidental injury and which require repositioning (except for preventive treatment) of teeth to establish normal occlusion.

E. The term “*ordered*” means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays, or onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.

X. Accidental Dental Injury

Payments for covered dental services related to the repair of accidental injury to sound natural teeth due to a sudden unexpected impact from outside the mouth will not count against the annual benefit limit or the lifetime orthodontic limit. Regular copayments will be required for all such services.

APPENDIX D

VISION COVERAGE

I. Enrollment Classifications

Vision coverage for a primary enrollee shall include coverage for secondary enrollees as defined in the Program.

II. Description of Benefits

Vision benefits will be payable, subject to the conditions herein, if an enrollee incurs a covered vision expense.

III. Definitions

As used herein:

A. “*Ophthalmologist*” means any licensed doctor of medicine or osteopathy legally qualified to practice medicine, including the diagnosis, treatment, and prescribing of lenses related to conditions of the eye.

B. “*Optometrist*” means any person legally licensed to practice optometry as defined by the laws of the state in which the service is rendered.

C. “*Optician*” means one who makes or sells eyeglasses prescribed by an ophthalmologist or optometrist to cure or correct defects in the eyes, and grinds the lenses or has them ground according to prescription, fits them into a frame, and adjusts the frame to fit the face.

D. “*Participating provider*” means an ophthalmologist, optometrist, or optician who has signed an agreement with the carrier covering

reimbursement, quality, service standards and other terms and conditions connected with providing covered vision services to enrollees.

E. “*Nonparticipating provider*” means an ophthalmologist, optometrist, or optician who has not signed an agreement with the carrier covering reimbursement, quality, service standards and other terms and conditions connected with providing covered vision services to enrollees.

F. “*Reasonable and customary charge*” means the actual amount charged by an ophthalmologist, optometrist, or optician for a service rendered or materials furnished but only to the extent that the amount is reasonable, taking into consideration the following:

- 1.** the usual amount which the individual provider most frequently charges the majority of patients or customers for a similar service rendered or materials furnished;
- 2.** the prevailing range of charges made in the same area by providers with similar training and experience for the service rendered or materials furnished;
- 3.** unusual circumstances or complications requiring additional time, skill, and experience in connection with the particular service rendered or materials furnished.

As used in this Appendix, “reasonable and customary charge” also refers to scheduled or other contracted amounts of payment used by carriers with participating provider arrangements.

The carrier is responsible for determining the appropriate reasonable and customary charge for a given provider and service or material, and such determination shall be conclusive.

G. “*Contact lenses*” means ophthalmic corrective lenses, as prescribed by an ophthalmologist or optometrist, to be fitted directly to the enrollee’s eyes.

H. “*Lenses*” means ophthalmic corrective lenses, as prescribed by an ophthalmologist or optometrist, to be fitted into a frame.

I. “*Frame*” means a standard eyeglass frame into which two lenses are fitted.

J. “*Covered vision expense*” means the reasonable and customary charges for vision care services and materials, as described in Section IV., when provided by ophthalmologists, optometrists, and opticians for each enrollee.

K. “*Corrective eye surgery*” means a surgical procedure used to alter the cornea or shape/surface of the eye in order to improve visual acuity, correct vision conditions such as myopia, hyperopia or astigmatism and reduce or eliminate the reliance on eyewear. Such surgeries can include, but are not necessarily limited to, Laser-assisted In-Situ Keratomileusis (LASIK), PhotoRefractive Keratectomy (PRK) and Radial Keratotomy (RK).

IV. Benefits

Benefits will be paid for the covered vision expenses described in A., B., and C. below, less any copayment as described in D. below.

A. Vision Examinations:

1. Refraction, including case history, coordinating measurements, and tests,
2. The prescription of glasses where indicated; and
3. Examination by an ophthalmologist, upon referral by optometrist, within 60 days of a vision examination by the optometrist.

B. Lenses and Frames:

When lenses are prescribed by an ophthalmologist or optometrist, the necessary materials and professional services connected with the ordering, preparation, fitting, and adjusting of:

1. Lenses (single vision, bifocals, trifocals, lenticular). If the enrollee selects lenses, the size of which results in an additional charge, only the reasonable and customary charge for normal size lenses of the same material and prescription will be considered a covered vision expense. If the enrollee selects photochromic lenses or lenses with a tint other than Number 1 or Number 2, only the reasonable and customary charge for clear lenses of the same material and prescription will be considered a covered vision expense.

2. Contact lenses following cataract surgery, or when visual acuity cannot be corrected to 20/70 in the better eye except by their use, or when medically necessary due to keratoconus, irregular astigmatism or irregular corneal curvature. If contact lenses are prescribed for any other reason, \$80 is the maximum amount that will be considered a covered vision expense.

3. Frames. If frames are obtained from a participating provider, the enrollee may make a selection from the display shown by the participating provider and there will be no out-of-pocket expense to the enrollee other than as described under “Copayments”. If the enrollee obtains frames from a nonparticipating provider, \$24 is the maximum amount that will be considered a covered vision expense.

C. Corrective Eye Surgery: Effective January 1, 2004, corrective eye surgery performed by an ophthalmologist will become a covered service. Coverage includes any related pre and post-surgical professional services, facility expense and medically necessary supplies. Coverage is subject to the following provisions:

1. An enrollee may not receive benefits for both corrective eye surgery and for frames and/or lenses (including contact lenses) in the same calendar year;

2. Upon proof of payment to the corrective eye surgery provider, the carrier will reimburse the primary enrollee for covered expenses, up to the lesser of the charges or the maximum benefit of \$295.00 in any four (4) year period; and

3. An enrollee receiving benefits for corrective eye surgery in any one calendar year will be ineligible for lens (including contact lens) and/or frame benefits for that year and three (3) subsequent years. For example, an enrollee undergoing corrective eye surgery in 2004 would be eligible for lens and/or frame benefits in 2008. Such enrollees will be eligible for benefits for an annual exam, and will have access to the participating provider fee schedule for non-covered services and for lenses and/or frames for which no benefits are payable.

D. Copayments: For each enrollee, there is a \$7.00 copayment applicable to the covered vision expense for each vision examination and a \$10.00 copayment for the combined covered vision expenses for lenses, contact lenses, and frames. The total copayment for each enrollee, during a calendar year, will not exceed \$17.00.

V. Frequency Limitations

For each enrollee, there are the following limitations on the frequency with which charges for certain services and materials will be considered covered vision expenses:

Vision Examination	Once during a calendar year, except as provided in Section IV.A.3.
Lenses and Contact Lenses	Once during a calendar year, except as provided in Section IV.C.
Frames	Once during two consecutive calendar years, provided in Section IV.C.

The limitations on lenses, contact lenses, and frames apply whether or not they are a replacement of lost, stolen, or broken lenses, contact lenses, or frames.

VI. Exclusions

- A.** Any lenses which do not require a prescription;
- B.** Medical or surgical treatment of the eye, except as provided in Section IV.C.;

C. Drugs or any other medication;

D. Procedures determined by the carrier to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonic lenses, and tonography;

E. Vision examinations or materials furnished for any condition, disease, ailment, or injury arising out of or in the course of employment;

F. Vision examinations performed and lenses and frames ordered:

1. before the enrollee became covered for this coverage;

2. after the termination of the enrollee's coverage;

3. to the extent that they are obtained without cost to the enrollee.

VII. Vision Network

A. The carrier has established a network of participating providers who agree to accept reimbursement according to a schedule for the covered vision services and materials described in Section IV. A. and B. without enrollee copayments.

B. If an enrollee uses a participating provider to obtain covered services, the carrier will reimburse

the provider, without enrollee copayment, as specified below:

1. the scheduled amount (which shall be payment in full) for eye examinations; normal-size clear, Number 1 or Number 2 tinted lenses; and medically necessary contact lenses (see Section IV. B.1. and 2.);

2. the scheduled amount (which shall be payment in full) for eyeglass frames with a retail value of \$80.00 or less. If an eyeglass frame with a retail value greater than \$80.00 is selected, the enrollee will be responsible for the discounted price (participating providers discount frames with the retail cost in excess of \$80.00), less \$24.00; and

3. the scheduled amount of \$65.00 for contact lenses, which do not meet the criteria in Section IV.B.2. The enrollee will be responsible for any amount greater than \$80.00.

C. If an enrollee resides 25 miles or less from a participating provider but obtains covered services from a non-participating provider (other than an ophthalmologist) the carrier will reimburse the enrollee the scheduled amounts. The enrollee will be responsible for paying the provider, including any remaining balance. Reimbursement to the enrollee for covered services received from non-participating ophthalmologists will be made at the reasonable and customary amount, less the enrollee copayment (see Section IV. D.).

D. If an enrollee resides more than 25 miles from a participating provider and obtains covered services from a non-participating provider (including an ophthalmologist), the carrier will reimburse the enrollee in accordance with Section IV. above.

APPENDIX E

MANUAL TRANSMISSION OF MUNCIE, LLC (FORMERLY NEW VENTURE GEAR, MUNCIE, INDIANA)

APPENDIX F

GM TEMPORARY EMPLOYEE HEALTH CARE PLAN

The GM Temporary Employee Health Care Plan (“Temp Plan”) is a component of the General Motors Hourly Health Care Program (the Program), applicable as described in this Appendix F. The Temp Plan incorporates the provisions of the Program except as set forth in this Appendix.

Section 1. Establishment, Financing and Administration of the Plan

The provisions of Article I of the Program are incorporated into the Temp Plan in their entirety.

Section 2. Health Care Coverages

The provisions of Article II of the Program are incorporated into the Temp Plan with the following modifications:

1. Enrollees in the Temp Plan are not eligible to enroll in the Health Maintenance Organization Operation as described in Article II.4(a) of the Program.

2. The Cost Sharing provisions of the Traditional Care Network (TCN), Article II, 4(b)(6), 4(b)(7), 4(b)(8), 4(b)(9), 4(b)(12), and 4(b)(13) of the Program do not apply to the Temp Plan.

- A. Covered services, as defined in Appendices A and B of the Program, when received from network providers are subject to the following:

(1) All covered services, except for those listed in 2.2.A.(2) below, when received from network providers are subject to an annual deductible of \$300 per individual enrollee and an annual deductible of \$600 per family. No more than \$300 for an individual may be counted toward satisfying the family deductible, but the family deductible can be met from a total aggregate of all family members without any individual meeting the individual deductible amount.

(2) The following services when received from network providers do not apply to the deductible or out-of-pocket maximum.

(a) certain preventive services, certain screenings, and certain diagnostic tests/examinations received from network providers, as set forth in Appendix A, III.E.3.n of the Program, which are exempt from deductibles, co-payments, or co-insurance;

(b) physician office visits to network providers, which are subject to a 100% co-insurance per visit;

(c) retail health clinic visits are subject to a 100% co-insurance for each visit to an in-network retail health clinic for covered services;

(i) retail health clinic visits to a non-network provider are not covered and are the enrollee's responsibility.

(d) telehealth visits are subject to a 100% co-insurance for each visit with an approved telehealth provider for covered services;

(i) telehealth visits with a non-preferred vendor or to a non-network provider are not covered and are the enrollee's responsibility.

(e) outpatient mental health services co-insurance as described in Section 5.2.A. of this Appendix;

(f) outpatient substance abuse treatment co-insurance as described in Section 5.2.B. of this Appendix; and

(g) prescription drug coverage co-payments as described in Section 5.1.A. of this Appendix.

(3) After the annual deductible has been satisfied, payment for covered services obtained from network providers will be limited to 90% of the network allowed amount, up to a calendar year combined maximum out-of-pocket cost for deductibles and co-insurance of \$1,000 for an individual and \$2,000 for a family. No more than \$1,000 for an individual may be counted toward satisfying the family out-of-pocket maximum, but the family out-of-pocket maximum can be met from a total aggregate of all family members without any individual meeting the individual out-of-pocket maximum amount.

(4) The annual deductibles and out-of-pocket maximums are to be shared between medical and mental health/substance abuse services.

B. Covered services, as defined in Appendices A and B of the Program, when received from non-network providers are subject to the following:

(1) All covered services when received from non-network providers are subject to an annual deductible of \$1,200 per individual enrollee and an annual deductible of \$2,100 per family. No more than \$1,200 for an individual may be counted toward satisfying the family deductible, but the family deductible can be met from a total aggregate of all

family members without any individual meeting the individual deductible amount.

(2) Office visits to non-network providers, without an approved advance referral, are not covered and are the enrollee's responsibility.

(3) After the annual deductible has been satisfied, payment for covered services obtained from non-network providers will be limited to 65% of the network allowed amount for the same service or, if less, the actual charge. There is no out-of-pocket maximum limitation for services received from non-network providers.

(4) The annual deductibles are to be shared between medical and mental health/substance abuse services.

(5) If the enrollee is referred by a network provider and receives approval for the referral prior to receiving services from a non-network provider, the services will be treated as if performed by a network provider and will be subject to the deductibles, co-insurance, and out-of-pocket maximums as described in Section 2.2.A.

(6) Services provided by non-network providers in a situation in which, according to Program standards, the enrollee does not have the ability or control to select network provider to perform the service, will be applied to the network deductible, co-insurance and out-of-pocket maximum described in Section 2.2.A. In such situations, if the provider attempts to collect an amount in excess of the allowed amount from the enrollee, the carrier will defend the enrollee on the basis that the allowed amount is the reasonable and customary reimbursement for the services or supplies in question.

(7) With the exception of situations in which subsection 2.2.B.(5) and 2.2.B.(6) of this Appendix, apply, amounts above the carrier allowed amount are the responsibility of the enrollee. Such amounts do not count toward the deductible in subsection 2.2.B(1).

Section 3. Enrollment, Eligibility, Commencement, Contributions and Continuation

The provisions of Article III of the Program are incorporated into the Temp Plan with the following modifications:

1. Eligibility for the Temp Plan is limited to those Employees defined as Temporary Employees under the provisions of the 2019 National Agreement between the UAW and General Motors LLC in Attachment B to Appendix A Re: Workforce Composition.

2. Temp Plan enrollees are not eligible for coverages under Appendix C (Dental Plan) of the Program or Appendix D (Vision Plan) of the Program.

3. The provisions of Article III, Sections 2, 3, 4, 5(c) and 5(d) are inapplicable to the Temp Plan.

A. The Company shall make contributions for any month in which the employee is in active service and eligible for coverage.

B. Coverage shall automatically cease as of the last date of the month in which the employee quits, is discharged, is placed on lay-off or placed on an approved leave of absence.

C. Employees Returning to Active Work

(1) If an employee's coverage was discontinued due to layoff or an approved leave of absence, and if the employee returns to active employment directly following such layoff or leave, the employee shall be eligible for reinstatement of all coverage immediately on the date of return to active work with the Company.

(2) If an employee's coverage is discontinued due to quit or discharge, the employee shall not be eligible for coverage until 91 days from the date of rehire.

4. The provisions of Article III, Sections 6 and 8 of the Program are inapplicable to the Temp Plan. The opportunity for survivors of a Temporary Employee to continue coverage or for a Temporary Employee to continue coverage post-employment or for periods not in active service will be limited to self-pay continuation that may be available under federal law. Temporary Employee to continue coverage or for Temporary Employee to continue coverage post-employment or for periods not in active service will be limited to self-pay continuation that may be available under federal law.

Section 4. Definitions

The provisions of Article IV of the Program are incorporated in the Temp Plan in their entirety.

Section 5. Plan Coverages

1. The provisions of Appendix A of the Program are incorporated into the Temp Plan with the following modifications:

A. Appendix A, III.G.2.a. of the Program does not apply to the Temp Plan. The following will apply instead:

Prescription Drugs (Retail and Mail Order)	
Generic	\$7.50/script
Brand	\$15.00/script

B. Appendix A, III.G.3.5. of the Program, Limitations and Exclusions, is modified to include the exclusion of coverage for erectile dysfunction (ED) drugs.

2. The provisions of Appendix B of the Program are incorporated into the Temp Plan with the following modifications:

A. The cost share provisions of Appendix B, II.B.4.a and III.E.2.b.(2)(a) do not apply to the Temp Plan. They are replaced by the following: An enrollee is eligible for the following outpatient mental health visits with a panel provider, or to a non-panel provider with advance referral visits 1-20 covered at 100%, visits 21-35 covered at 75%, and visits 36 and over are covered with 100% co-insurance per visit for both facility and professional services per calendar year.

B. The cost share provisions of Appendix B, II.B.4.b. and III.E.2.b.(2)(b) do not apply to the Temp Plan. They are replaced by the following: An enrollee is eligible for the following outpatient substance abuse visits with a panel provider, or to a non-panel provider with advance referral: visits 1-35 covered at 100% and visits 36 and over are covered with 100% co-insurance per visit for both facility and professional services per calendar year.

C. The provisions of App. B.III.A.2 and D.2 do not apply to the Temp Plan. They are replaced by the following: Inpatient services by non-panel providers are subject to the cost-share provisions of Section 2.2.B of this Appendix.

3. The provisions of Appendices C and D of the Program are not incorporated into and do not apply to the Temp Plan.

**MISCELLANEOUS
HEALTH CARE
PROGRAM
DOCUMENTS**

Statement of Intent

Notwithstanding the provisions of Exhibit A, Section 3(c) of the General Motors Hourly-Rate Employees Pension Plan; Exhibit D, Articles V and VI of the Supplemental Unemployment Benefit Plan, and the Items Agreed to by UAW-GM SUB Board of Administration; which deal with local union representatives for each of these benefit plan areas, the Company and the Union agree as follows:

1. Appointment of Benefit Representatives

(a) Local union benefit representative(s) and alternate(s) shall be appointed or removed by the GM Department of the International Union. Management benefit representative(s) shall be appointed or removed by Management.

(b) Temporary replacement appointments may be made by the local union President for a minimum of one week and a maximum of four weeks. Replacement appointments for any absence in excess of four weeks also shall be made by the GM Department of the International Union. Replacement appointments in situations when the benefit representative(s) and alternate(s) are both absent but for less than one week and are on a leave of absence pursuant to the provisions of Paragraph 109 of the UAW-GM National Agreement may be made by the local union President. Any problems that may arise under this procedure may be discussed by the Company with the GM Department of the International Union.

(c) A local union benefit representative shall be an employee of the Company having at least one year of seniority, and working at the plant where, and at the time when, such employee is to serve as such

representative or alternate. No such representative or alternate shall function until written notice has been given to the Company by the GM Department of the International Union. In the case of temporary appointments, the notice should be given to local Management with additional copies forwarded to the GM Department of the International Union and the Company.

2. Number of Local Union Benefit Representatives

(a) In plants having a total of less than 600 employees, there may be one local union benefit representative and one alternate.

(b) In plants having a total of 600 but less than 1,200 employees, there may be two local union benefit representatives and two alternates.

(c) In plants having a total of 1,200 but less than 2,000 employees, there may be three local union benefit representatives and three alternates.

(d) In plants having a total of 2,000 but less than 5,000 employees, there may be four local union benefit representatives and three alternates. If such plants have a total of 1,400 or more employees on the second and third shifts combined, there may be five local union benefit representatives and two alternates.

(e) In plants having a total of 5,000 but less than 8,000 employees, there may be five local union benefit representatives and two alternates.

(f) In plants having a total of 8,000 but less than 10,000 employees, there may be six local union benefit representatives and two alternates.

(g) In plants having a total of 10,000 or more employees, there may be seven local union benefit representatives and two alternates.

The number of employees as used herein shall include active employees, employees on sick leave of absence, and employees on temporary layoff.

3. Of the total number of local union benefit representatives and alternates otherwise available, one or more representatives and alternates may be assigned to the second shift or third shift so long as the total number of representatives and alternates set forth in Paragraph 2. above is not exceeded.

4. When plant population changes occur which would increase or decrease the number of local benefit plan representatives, such population changes must be in effect for a period of six consecutive months before such adjustment is made in the number of representatives, unless such population change results from the discontinuance or addition of a shift or the opening or closing of a plant. In the event of a cessation of operations, the Company, at the request of the UAW General Motors Department of the International Union, will provide for the continuance of Benefit Representation. Other situations involving a sudden significant change in the number of employees at a location may be discussed by the Company and the GM Department of the International Union.

5. Benefit Plan districts will be established by local mutual agreement. Only one local union benefit representative will function in a benefit district and will handle specified benefit plan problems raised by employees within that district pertaining to the Pension Plan, Life and Disability Benefits Program, Health Care Program, and Supplemental Unemployment Benefit

Plan Agreements. An alternate will be permitted to function in the absence of a local benefit plan representative on the benefit plan representative's shift.

6. Any local union benefit representative may function as the member of the Pension Committee, as the member of the local Supplemental Unemployment Benefit Committee, or handle benefit problems under the Life and Disability Benefits Program and the Health Care Program with respect to employees in such representative's Benefit Plan district. An alternate may function in the absence of a local union benefit representative.

7. The time available to a local union benefit representative and alternate with respect to a Benefit Plan district may not exceed eight (8) regular working hours of available time in a day.

(a) On a local union benefit representative's regular shift and without loss of pay, such local union benefit representative(s) may accompany the management benefit representative for a mutually agreeable joint off site visit to a local hospital, an impartial medical opinion clinic or a health maintenance organization, or other similar type joint ventures, with respect to benefit plan matters.

(b) A local union benefit representative attending a scheduled Management-Union Benefit Plan meeting on a shift other than the representative's regular shift will be paid for time spent in such meeting.

(c) One local union benefit representative attending the local union retiree chapter meeting will be paid for time spent in such meeting.

(d) The time spent in such local union retiree chapter meetings, off-site visits or Management-Union Benefit Plan meetings will not result in additional hours which exceed regularly scheduled shift hours, overtime premiums or an increase in representation time being furnished as a result of the representative(s) not working a full shift on the representative's regular shift.

8. The local union benefit representative shall be retained on the shift to which the representative was assigned when appointed as such representative regardless of seniority, provided there is a job that is operating on the representative's assigned shift which the representative is able to perform.

9. The Benefit Plans Health and Safety office may be used by local union benefit representatives during their regular working hours:

(a) To confer with retirees, beneficiaries, and surviving spouses who ask to see a local union benefit representative with respect to legitimate benefit problems under the Pension Plan, Life and Disability Benefits Program and Health Care Program Agreements.

(b) If the matter cannot be handled appropriately in or near the employee's work area, to confer with employees who, during their regular working hours, ask to see a local union benefit representative with respect to legitimate benefit problems under the Pension, Life and Disability Benefits, Health Care, and SUB Agreements.

(c) To confer with employees who are absent from, or not at work on, their regular shift and who ask to see a local union benefit representative with respect to legitimate benefit problems under the Pension, Life and Disability Benefits, Health Care, and SUB Agreements.

(d) To write position statements and to complete necessary forms with respect to a case being appealed to the Pension or SUB Boards by an employee in the local union benefit plan representative's Benefit Plan district, and to write appeals with respect to denied life, health care, and disability claims involving employees within the representative's Benefit Plan district.

(e) To file material with respect to the Pension, Life and Disability Benefits, Health Care, and SUB Agreements.

(f) To make telephone calls with respect to legitimate benefit problems raised by employees under the Pension, Life and Disability Benefits, Health Care, and SUB Agreements.

10. Notwithstanding Item 7 of this Statement of Intent, during overtime hours, Local Union Benefit Representatives will be scheduled to perform in-plant benefit related activities, if they would otherwise have work available in their equalization group.

PROCESS FOR VOLUNTARY REVIEW OF DENIED CLAIMS

Under Section 502(a) of ERISA, employees who have received an adverse final determination from a carrier on a claim may initiate a civil action at law. To afford employees a voluntary alternative means by which they can seek review and possible reconsideration of a disputed health care claim or question of coverage, internal procedures of the Company, as Plan Administrator of the Health Care Program for Hourly Employees, will provide a process. In connection with this process, the Program:

- 1.** Waives any right to assert that a primary enrollee has failed to exhaust administrative remedies because the primary enrollee 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.

Step 1. Following receipt of a final determination from the Control Plan or carrier with regard to the appeal of a denial of a claim in full or in part, an employee may request the local union benefit representative to review the disputed claim with a designated Plans Workforce representative.

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 the employee's 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 coverages 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 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.

UNDERSTANDINGS WITH RESPECT TO THE NATIONAL ACCOUNT PROGRAM

1. Master Group Operating Agreement

By signed agreement with the Company, the Control Plan shall be responsible for the administration of hospital, surgical, medical, prescription drug, and hearing aid coverages as described in Appendix A. The Control Plan shall accept the responsibility for assuring that such coverages are administered according to the specifications and conditions set forth in Appendix A. To this end the Control Plan shall accept responsibility for the implementation and overall administration of a National Account Program, and any applicable local medical carrier plans serving as carriers under the Health Care Program.

2. Areas Subject to the National Account Program

Hospital, surgical, medical, prescription drug, and hearing aid coverages shall be provided through the National Account Program for all enrollees under the Health Care Program except in those areas in which such coverages are provided through another carrier.

3. Administration and Implementation

It is the intent and expectation that all local plans serving the areas described in Section 2 above will participate in the National Account Program by entering into a formal participation agreement with the Control Plan to arrange for and/or administer the specified National Account Program coverages in their respective geographic areas. If a local plan is unable or unwilling to arrange for and/or administer any or all of the specified coverages of the National Account

Program, this fact shall be formally reported by the Control Plan to the parties.

If a local plan does not arrange for and/or administer the specified coverages, the Control Plan shall advise the Company and the Union and recommend possible appropriate actions including those set forth below.

The Control Plan may recommend that it:

- Arrange for the specified coverages with the administration being handled by the local plan, or
- Arrange for those portions of the specified coverages not provided by the local plan with the administration being handled by the local plan, or
- Arrange for and administer the coverages in a local plan area if the local plan does not participate in any capacity, or
- Arrange for another local plan in the region to provide and/or administer the specified coverages, or
- Arrange for the specified coverages with the administration being handled by another local plan in the region.

The Company and the Union shall then instruct the Control Plan of the appropriate action to be taken.

It also is the intent and expectation that the Control Plan and local plans shall perform their respective obligations as set forth in the "Understandings With Respect To Utilization Review and Cost Containment" and provide data and reports as mutually requested by the Company and the Union.

4. Informed Choice Plan Administration Manual

(a) Contents

An Informed Choice Plan Administration Manual developed for the Health Care Program for use by all participating local plans and carriers shall be brought up to date as necessary. The Control Plan shall have the responsibility for any necessary revisions of the Manual so as to describe the coverages and performance standards specified for the TCN options under the Informed Choice Plan. Among other items, the Manual should:

- (1) define and explain Program standards;
- (2) explain the coverages and the regulations governing the payment of benefits;
- (3) include the standardized administrative practices and interpretations which affect benefit payments;
- (4) list the limitations and exclusions of the coverages;
- (5) define all those terms related to the coverages provided (such as facility, physician, etc.); and
- (6) define the data to be provided with respect to the operations of the National Account Program.

(b) Review

The Control Plan shall forward copies of any proposed Administration Manual revisions to the Company and the Union. The Company and the Union,

after joint discussion and review, will advise the Control Plan of any action to be taken regarding the proposed revisions.

The Control Plan shall issue the official controlling revised edition of such Administration Manual sections within 30 days of receipt of such advice of action.

(c) *Administrative Practices*

The Control Plan may amend its administrative practices and interpretations as established in its Administration Manual in order to better facilitate the implementation of the coverages provided through the National Account Program. If, in the judgment of either the Company or the Union, such changes in administrative practices and interpretations materially affect the benefits in the Health Care Program, the mutual consent to such change by the Company and the Union is required.

(d) *Interpretation*

The Control Plan shall provide written replies to questions from the Company, Union, or carriers regarding the interpretations of the Administration Manual with copies of such interpretations provided to the Union, the Company, and all affected carriers.

5. Performance

The Control Plan shall be responsible to ensure that any local plans participating in the National Account Program provide the scope and level of coverages as specified in the Health Care Program and in the Administration Manual and meet performance standards as set by the Control Plan, subject to the review of the Company and the Union. The Control

Plan may, in exercising its responsibilities, audit local plans, if any, to determine if they are providing the specified level of coverages.

6. Other Carriers

Any other carrier not participating in the National Account Program shall provide the scope and level of hospital, surgical, medical, prescription drug and hearing aid coverages defined in Appendix A in those areas where it provides such coverages, subject to the condition that carriers or other organizations may by mutual agreement of the Company and the Union be substituted. Such coverages shall be administered as applicable in accordance with the Administration Manual prepared by the Control Plan. Any interpretation of the scope or level of coverages described in the Administration Manual shall be referred to the Control Plan for clarification. Any other carrier not participating in the National Account Program shall administer the Health Care Program in accordance with such interpretations provided by the Control Plan in a manner consistent with the Administration Manual and such interpretations. Carriers not participating in the National Account Program desiring to deviate from the administrative standards and procedures shall submit the proposed deviations to the Company and Union for review and approval prior to implementation.

7. Relationships to Providers of Service and Participation in Community Health Planning

It is expected that the Control Plan, the participating local plans and any other carrier will maintain continuing and close relationships with the providers of health services and will actively participate in comprehensive community health planning.

8. Miscellaneous Administrative Understandings

(a) The Control Plan has been requested to ask local plans participating in the National Account Program to do the following, consistent with applicable Federal regulations:

- Designate a person or persons whom individuals, Union and Management representatives may contact regarding the status of individual claims or individual enrollee problems. Local plans will be requested to keep the Union and Plans Workforce representatives advised of the name of the person(s) to whom such inquiries should be made.

- Continue the periodic follow-up procedure for claim inquiries and advise the party making the inquiry of the status of the local plan's investigation regarding specific claims, subject to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Submit written replies upon request of individuals, including Plans Workforce or Union representatives, regarding inquiries concerning claims.

- Continue the review of inquiries by physicians employed or selected by the local plan if such inquiries exist because of a question regarding a medical opinion.

(b) The Control Plan has established an appeal procedure to resolve adverse benefit determinations involving an interpretation of the scope or level of hospital, surgical, medical, prescription drug and hearing aid coverages under the National Account Program. Final determination of any appeals which

Misc. (Nat'l. Account Program)

involve the interpretation, the scope or level of such coverages under the National Account Program will be the responsibility of the Control Plan.

UNDERSTANDINGS WITH RESPECT TO DENTAL COVERAGE

1. Administrative Manual

Policies, procedures and interpretations to be used in administering dental coverage shall be incorporated in an Administrative Manual prepared by the carrier, subject to review and approval by the Company and the Union. Among other things the Manual shall:

- A.** Explain the benefits and the rules and regulations governing payment.
- B.** Include administrative practices and interpretations which affect benefits.
- C.** Define professionally recognized standards of practice to be applied to services and procedures.
- D.** List the eligibility provisions and limitations and exclusions of the coverage, and procedures for status changes and termination of coverage.
- E.** Provide the basis upon which charges will be paid, including provisions for the benefit payment mechanism and protection of enrollees against excess charges.
- F.** Provide for cost and quality controls by means of predetermination of procedures and charges, utilization and peer review, clinical post-treatment evaluation, and case reviews involving individual consideration of fees or treatment.

2. Denturists

Review will be given to possible inclusion of treatment by denturists in certain states where they are licensed.

UNDERSTANDINGS WITH RESPECT TO VISION COVERAGE

1. Administrative Manual

Policies, procedures and interpretations to be used in administering vision coverage shall be incorporated in an Administrative Manual prepared by the carrier, subject to review and approval by the Company and the Union.

2. Cost and Quality Controls

The carrier will undertake the following review procedures and mechanisms and report annually to the Company-Union Committee:

(a) *Utilization Review*

Analysis of various reports displaying such data as provider/patient profiles, procedure profiles, utilization profiles and covered vision expense payment summaries to:

(1) evaluate the patterns of utilization, cost trends and quality of care;

(2) establish guidelines and norms with respect to profiles of practice in order to identify providers with either a high or low percentage of prescriptions issued in relation to the number of enrollees examined, with a high percentage of lenses provided under vision coverage that fail the minimum perception criteria for new lenses or other departures from the guidelines; and

(3) establish the percentage of vision benefits that are paid to participating providers.

(b) *Price Reviews*

Where possible, price reviews or other audit techniques shall be conducted to examine records, invoices and laboratory facilities and materials and to verify that charges for enrollees are the same as for other patients. These examinations may include enrollee interviews and clinical evaluations of services received.

(c) *Evaluation of Services Received*

On a random or selective basis, enrollees who have received services under vision coverage will be selected for subsequent evaluation and examination by consulting providers to ensure that the services reported were actually provided and were performed in accordance with accepted professional standards. Such evaluations may include (1) reexaminations to determine the accuracy of the prescription, (2) the quality of lenses and frames, (3) whether the vision testing examinations administered by providers conform to professional standards, and (4) other aspects of the services provided.

(d) *Survey of Services Received*

On a random or selective basis, enrollees who have received services under vision coverage may be sent a questionnaire to:

(1) determine the level of satisfaction with respect to these services;

(2) determine whether services for which vision benefits were paid were actually received;

(3) determine whether providers recommend unnecessary optional services or supplies; and

(4) identify other problem areas.

(e) *Claims Processing*

The carrier may conduct audits of claims being processed such as an analysis of enrollee histories and screening for duplicate payments in addition to the normal eligibility, benefit and charge verifications.

(f) *Peer Review*

When the carrier or an enrollee does not agree with the appropriateness of charge or service provided, an appeal procedure involving peer review may be utilized. Peer review may also be used to resolve situations involving providers with aberrant utilization patterns. The carrier will seek to establish peer review where it does not exist.

UNDERSTANDINGS WITH RESPECT TO UTILIZATION REVIEW AND COST CONTAINMENT

All carriers shall implement and maintain processes for predetermination, concurrent utilization review, retrospective utilization review and focused utilization review and case management consistent with the criteria set forth below and in the Informed Choice Plan Administration Manual. The Control Plan shall have responsibility for assuring that local plans under the National Account Program have such utilization review processes in their respective local plan areas.

Definitions:

Predetermination:

The process by which the necessity for a given health care service, appropriateness of the service or the proposed setting for the service, is reviewed and approved by a carrier before the performance of such service. The review and approval are performed by qualified health care professionals, as determined by the Control Plan, employed or retained by the carriers, using accepted standards to examine pertinent medical documentation of the need, appropriateness and setting for such service.

Concurrent Utilization Review:

The process by which the continued need for inpatient treatment is reviewed while the patient is receiving inpatient care. Determination of the need for continuation of such treatment is performed by qualified health care professionals, as determined by the Control Plan, employed or retained by the carriers,

using accepted standards to review pertinent medical documentation of such need.

Retrospective Utilization Review:

The process by which the necessity, appropriateness, and setting of a given health care service is reviewed following the performance of the service. The review is performed by qualified health care professionals, as determined by the Control Plan, employed or retained by the carriers, using accepted standards to examine pertinent medical documentation of the need, appropriateness, and setting for such service.

Focused Utilization Review:

The process by which intensive review of certain providers (professionals and facilities) and/or diagnoses is reviewed. The review is performed by qualified health care professionals, as determined by the Control Plan, employed or retained by the carriers, to audit the necessity of a given health care service, appropriateness of the service, the setting of the service, the quality of care rendered, and the financial accuracy of claims submitted for reimbursement related to such services.

I. Predetermination

A. Under the Traditional Care Network option, the carriers provide predetermination for the following items:

1. Hospital admissions except maternity and emergency (emergency admissions are to be reported to and reviewed by the carriers within 24 hours of inpatient admission);

2. Nonemergency, outpatient medical or surgical procedures performed in a facility or a physician's office which are associated with certain diagnoses determined by retrospective utilization review to be subject to over-utilization and amenable to control by predetermination;

3. Ancillary services provided in inpatient and outpatient settings (including home health care) which are associated with certain diagnoses determined by retrospective utilization review to be subject to overutilization and amenable to control by predetermination;

4. Medical equipment, prosthetic and/or orthotic devices prescribed for certain medical conditions determined by retrospective utilization review to be subject to overutilization and amenable to control by predetermination;

5. Skilled nursing facility admissions; and

6. Selected foot surgery procedures.

If appropriate, all covered services listed above shall be referred to the carriers for predetermination according to standards and procedures set forth in the Administration Manual. However, the carriers may focus their review by diagnosis, treatment plan, and/or individual patient characteristics. The carriers may recommend outpatient or office settings as appropriate for selected procedures and diagnostic tests.

The predetermination of inpatient care shall include the designation of appropriate lengths of stay based on diagnosis, patient characteristics, and/or appropriate practice patterns. An appeal process for adjusting the assigned length of stay in individual cases will be

available for use as needed. The carriers will provide to the Company and the Union such data and reports on the performance of the predetermination program as may be requested.

B. The carriers shall establish and maintain a telephone service and other appropriate communication methods to provide accurate information to enrollees and providers regarding the program procedures and requirements. Such communications will specify the responsibilities of providers and enrollees in obtaining necessary predetermination. Such communications will include forms and letters, as appropriate, to indicate confirmation and non-confirmation and will be provided to physicians, facilities, and enrollees by the carriers. All such communications will be designed to assist providers and enrollees to secure the required predetermination.

C. The carriers shall provide timely written notification of any actions taken with respect to the predetermination process. Such notification will be mailed to the provider and the enrollee. Such notification shall be mailed within 24 hours following receipt by the carrier of oral or written request for predetermination.

D. An appeal procedure will be available for independent medical review of disputed decisions prior to receipt of services. Decisions resulting from such an appeal procedure will be final and binding on the provider, enrollee and carrier.

E. A procedure will be available for carriers to hold the enrollee harmless for errors of commission or omission involving the predetermination process over which the enrollee has no control. This procedure shall be published in the Administration Manual. The

carriers shall require participating providers to hold the enrollee harmless from the provider's errors of commission or omission involving the predetermination process.

F. The carriers shall monitor for and identify providers who have a pattern of inappropriately prescribing services. The carriers shall provide selective screening of such identified providers. The carriers also shall provide screening for diagnoses identified as being subject to such inappropriate practices.

II. Concurrent Utilization Review

The carriers shall provide a process of concurrent utilization review to supplement the predetermination process. Through this process of concurrent utilization review, the carriers shall identify providers who utilize services inappropriately and develop educational and/or corrective action programs for these providers.

III. Retrospective and Focused Utilization Review

The carriers shall develop a program to conduct ongoing retrospective reviews which will include audits of claims for medical necessity, appropriateness of services provided, treatment setting, quality of care, and financial accuracy. At the option of the carriers, this review can focus on specific diagnoses and/or providers identified as warranting such focused review.

Such review may occur post-payment; however, the carriers should develop and implement a plan for making this review, where practicable, pre-payment (or pre-settlement with respect to providers paid on a prospective basis).

IV. Pilot Programs

The Company-Union Committee shall develop or request the appropriate carrier or carriers to develop specifications for new or modified pilot programs for Committee review and evaluation. The pilot programs shall be implemented after Committee approval of the proposed program specifications and evaluation criteria, including mutually agreed upon modifications.

In development of these pilot programs, the Company-Union Committee or carrier(s) shall secure the advice of professional and medical associations, as appropriate.

Any pilot program may be modified or terminated by mutual agreement if it appears that positive results are not forthcoming.

V. Other Activities

The Company-Union Committee shall investigate, consider and, upon mutual agreement, engage in other activities that may have high potential for cost savings. This may involve instituting by mutual agreement other hospital, surgical, medical, prescription drug, hearing aid, dental, vision and substance abuse coverages pilot programs or extending the pilot programs in IV., above, to additional locations.

VI. Review

The results of any pilot programs and activities in IV. and V., above, will be reviewed prior to the expiration of the Collective Bargaining Agreement so that the parties to the agreement may be prepared to consider the continuation or modification of the pilot programs and other activities of the Company-Union Committee.

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

As we discussed during negotiations, national health care reform is an important objective for the Company and the Union as well. Consequently, the parties have participated in a number of joint activities at the state level and in Washington. The Company and Union seek to achieve health care reform that will address issues that are important to the welfare of the U.S. auto industry and specifically to the well-being of the Company and its employees.

The impact national health reform may have on the Health Care Program (hereinafter “the Program”) cannot be predicted with any certainty. Because these matters are unsettled, the Company and Union have agreed to maintain the following understandings regarding national health insurance:

Notwithstanding Article I, Section 4 of the Program, if, during the term of the Collective Bargaining Agreement between the Company and the Union signed today, any national health insurance act (other than a Workers Compensation or occupational health law)

is enacted or amended to provide any health care benefits for employees, retired employees, surviving spouses, and their dependents, which in whole or in part duplicate or may be

integrated with the benefits under the Program, the benefits under the Program shall be modified in whole or in any part, so as to integrate or so as to eliminate any duplication of such benefits with the benefits provided by such federal law. This integration shall be designed to maintain such integrated benefits as nearly comparable as practicable to the benefits provided in the Program. Such integration shall not result in persons covered under the Program having to pay deductibles or copayments for benefits which they would not otherwise pay under the Program;

If any such federal law is enacted or amended, as provided in the paragraph above, the Company will pay, beginning with the date benefits under such law become available and continuing through the expiration of the current Collective Bargaining Agreement, any premiums, taxes or contributions that employees who are eligible for Company-paid coverages under the Program may be required to pay under the law for benefits which may be integrated with the Program;

This includes payments that are specifically earmarked or designated for the purpose of financing the program of benefits provided by law, in addition to any premiums, taxes or contributions required of the Company by law. If such premiums, taxes or contributions are based on wages, the Company will pay only the premiums, taxes or contributions applicable to wages received from the Company; and

Any savings realized by the Company from integrating or eliminating any duplication of benefits provided under the Program with the benefits provided by law shall be retained by the Company.

These understandings are conditioned on the Company's obtaining and maintaining such governmental approvals as may be required to permit the integration of the benefits provided under the Program with the benefits provided by any such law; otherwise the Company and the Union shall meet and develop an acceptable alternative to accomplish the intent of this letter for the remaining term of the Agreement. The parties will meet promptly following the enactment of such legislation in order to assure a smooth implementation of and transition to the integrated program addressed in this letter.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

**UNDERSTANDINGS WITH RESPECT
TO EMPLOYEE CONTRIBUTIONS -
HEALTH MAINTENANCE
ORGANIZATIONS (HMOs)**

In calculating the Company's monthly contributions (and any required member contributions) toward the cost of coverage for eligible individuals electing a health maintenance organization under Article II, Section 4 of the Program, the following method will be used:

I. At the time of any change in the component premium rates (e.g., single, two-party, family) of either a health maintenance organization or the corresponding accrual rates for local carrier(s), the health maintenance organization's composite premium shall be compared to an adjusted local carrier's composite accrual rate developed by using comparable component rates of the local carrier(s) and the health maintenance organization enrollment mix of General Motors employees who are then members of the health maintenance organization. For purposes of these calculations, the rates of the local carrier(s) are defined the rates for the TCN option based on the adjusted composite rate.

If there are less than 30 General Motors primary enrollees in a health maintenance organization (which includes all new health maintenance organizations), the national enrollment mix of all General Motors primary enrollees in health maintenance organizations will be used in calculating its composite premium rate and comparing its rate to that of the corresponding local carrier(s) so as to produce more reasonable statistical results. Whenever possible, these calculations will employ separate enrollment mixes for General Motors hourly and salaried employee groups, respectively.

2. If the adjusted local carrier composite accrual rate is in excess of the health maintenance organization's composite premium, the Company shall pay the full premiums of eligible primary enrollees electing coverage through such organization. See Example #1.

3. If the health maintenance organization composite premium is in excess of the adjusted local carrier composite accrual rate, the Company's contribution on behalf of a primary enrollee in such health maintenance organization shall be limited to the amount obtained by multiplying the amount of the applicable component premium rate for the health maintenance organization by the ratio derived from the adjusted local carrier's composite accrual rate divided by the health maintenance organization's composite premium. The health maintenance organization member contribution amount shall be the difference between the appropriate health maintenance organization component rate less the applicable Company contribution. See Example #2.

Example #1

	Health Maintenance Organization		Carrier Monthly Accrual Rates*
	Enrollment Mix	Monthly Premium Rates*	
Single	16%	\$ 35.00	\$ 30.00
Two-Party	23	75.00	70.00
Family	61	100.00	110.00
Composite		\$ 83.85	\$ 88.00

*The calculation of Company and primary enrollee liability would be based on each specific health maintenance organization component rate.

The adjusted local carrier's composite accrual rate of \$88.00 is in excess of the health maintenance organization's composite premium of \$83.85. Therefore, even though the health maintenance organization single and two-party component rates exceed those of the local carrier, the Company will pay the full premiums of all members enrolled in the health maintenance organization.

Example #2

Single	16%	\$ 35.00	\$ 30.00
Two-Party	23	75.00	60.00
Family	61	100.00	100.00
Composite		\$ 83.85	\$ 79.60

The health maintenance organization's composite premium of \$83.85 is in excess of the adjusted local carrier's composite accrual rate of \$79.60. Shown below is the calculation of the Company's and primary enrollees' contributions toward payment of the health maintenance organization premiums.

- Health maintenance organization
 composite rate:\$83.85
- Adjusted local carrier
 composite rate:\$79.60
- Ratio of the adjusted local carrier composite
 accrual rate to the health maintenance
 organization composite premium:
 \$79.60 ÷ \$83.85 = .949
- Company and primary enrollee monthly liability

Health Maintenance Organization Component Rates*	Company Liability (Component x .949)	Primary Enrollee Liability
Single \$ 35.00	x .949 = \$33.22	\$1.78
Two-Party 75.00	x .949 = 71.18	3.82
Family 100.00	x .949 = 94.90	5.10

*The calculation of Company and primary enrollee liability would be based on each specific health maintenance organization component rate.

**UNDERSTANDINGS WITH RESPECT TO
SUPPLEMENTAL METHODOLOGY
FOR REVIEW OF HEALTH MAINTENANCE
ORGANIZATIONS (HMOs)**

For HMO rates which are to be effective on or after January 1, 1989, in addition to the HMO comparison methodology referenced in the previous letter, an additional comparison will be calculated as described below.

In reviewing the Company's monthly contributions (and identifying any enrollee contributions which would have been required under this supplemental methodology) toward the cost of coverage for primary enrollees electing an HMO under Article II, Section 4 of the Program, the supplemental methodology set forth below will be used.

For purposes of this review, the "local carrier's accrual rate" is defined as the composite accrual rates for the TCN option in the same service area as the HMO. Service areas are defined by zip codes and have been grouped together using, as a basis, the Metropolitan Statistical Area (MSA) concept developed by the Department of Labor, Bureau of Labor Statistics.

The local carrier's accrual rate shall include all coverages comparable to those provided by the HMO and included in the HMO's rates (e.g., hospital, surgical, medical, prescription drug and mail order prescription drug and mental health/substance abuse).

The composite premium rate of an HMO will be compared to the composite accrual rate of the local carrier(s) annually, for every MSA that is within the service area of the HMO. If the HMO's composite premium rate is in excess of the respective local carrier's composite accrual rate, the parties will not approve or will withdraw approval of such HMO. Accordingly, current enrollees may not be allowed to continue in the HMO. Any such enrollees may be required to elect another ICP option. Before taking the final step of discontinuing the offering of an HMO, the parties will examine alternative means to reduce the HMO's composite premium rate.

UNDERSTANDINGS WITH RESPECT TO HEALTH CARE – GENERAL

This will confirm our understanding with respect to the following matters under the Health Care Program, herein referred to as the Program, incorporated by reference in the Collective Bargaining Agreement:

1. Vision Coverage

If a health maintenance organization, referred to in Article II, Section 4(a) of the Program, decides it is able to provide its own vision coverage, the Company and the Union may arrange, by mutual agreement, for enrollees therein to be covered by the health maintenance organization's vision coverage, in lieu of the coverage referred to in Article II, Section 1(b) of the Program.

2. Departicipating Hospitals

The Company will request the Control Plan to assure that each participating carrier institutes the following procedure in the event a hospital departicipates.

(a) A plan will give adequate notice at the earliest possible date to enrollees of a hospital's departicipation and of the payment arrangements in such a departicipating situation.

(b) For those enrollees already hospitalized before a hospital departicipates, full covered benefits will be paid until the end of the hospital stay or until the available days of care are exhausted.

(c) For enrollees admitted during the first 30 days after the initial date of each hospital's departicipation, full covered benefits will be paid for all admissions to such departicipated hospital until the end of the

hospital stay or until the available days of care are exhausted. For enrollees admitted after such 30 days, the appropriate nonparticipating hospital rate shall apply, except as provided in (d), below.

(d) Upon admission in an emergency (as determined by the plan) to a hospital that has departicipated, when the enrollee cannot be safely moved to a participating hospital, the enrollee will be entitled to full covered benefits during the first five days of the hospital stay. After five days from the date of such emergency admission, payment will be at the appropriate nonparticipating hospital rate. If at any time during such an admission the enrollee is moved to a participating hospital, payment may be made for the reasonable charges for ground ambulance transfer of up to 25 miles, upon approval of the attending physician and the plan. This approval must be based on the physician's medical certification that the transfer will not endanger the enrollee's health and of plan certification that the subsequent stay will be of sufficient duration to justify the transfer. If transfer to a participating hospital cannot be arranged, either because such a transfer would endanger the enrollee's health or because the subsequent stay would not be of sufficient duration to justify transfer, full covered benefits will be paid until the end of such hospital stay or until the available days of care are exhausted.

(e) If such a hospital regains its participating status within six months after departicipating, the plan will retroactively make payments for the balance of the hospital's reasonable charges (as determined by the plan) for covered services for enrollees admitted during the period of departicipation. The plan shall arrange that such payments relieve the enrollees of any further financial obligation with respect to covered services received during the departicipation period, and that any

portion of such balance previously paid by the enrollee shall be refunded.

3. Nonparticipating Hospital Rates

(a) The plan's payment for inpatient room and board charges with respect to nonparticipating hospitals (other than psychiatric hospitals) will be up to a maximum of \$500 per day and payment for inpatient ancillary charges at such hospitals will be up to \$50 per day (a total of \$550 per day). Upon implementation, these daily benefit rates will supersede present benefit arrangements for inpatient services in nonparticipating, non-psychiatric hospitals in all plan areas. A maximum of \$50 will be paid to such hospitals for each condition for outpatient services, except as otherwise provided for treatment of certain medical emergencies and accidental injuries.

(b) Payment to nonparticipating hospitals (other than psychiatric hospitals) for emergency admissions will be as described in 2(d) above for deparicipating hospitals.

(c) Certain covered emergency services received in the outpatient department of a non-participating hospital will be paid on the same basis as if in a participating hospital. To qualify for payment, the claim must be for services related to a medical emergency or a serious bodily injury that requires immediate medical attention to avoid placing the enrollee's life in jeopardy, permanent damage to the enrollee's health or significant impairment of bodily functions. Treatment must be provided at the hospital immediately following the medical emergency or injury. Payment will not exceed the amount that would be paid to a participating hospital, and there can be no assurance that the payment will cover the entire amount billed by the hospital.

(d) Present benefit arrangements for payments of \$15 per day shall continue to apply to admissions to nonparticipating hospitals which are classified as psychiatric hospitals.

4. Nonparticipating Physician Rate

The plan's payment for services provided by a nonparticipating physician will be up to the reasonable and customary charge for the same service when provided by a participating physician, as determined by the plan.

5. Canadian Resident Coverage

The Company will continue arrangements to make available on an optional basis the hospital, surgical, medical, prescription drug, hearing aid, dental, vision, and substance abuse coverages, provided employees of GM Canadian operations, to employees and retirees of GM locations in the United States, including eligible surviving spouses of former U.S. employees, who live in Canada and for whom the Company contributes the full cost of their coverages.

The Canadian coverages, if elected, will be in lieu of coverages available at the GM U.S. location where employed or from which retired.

6. PPO Accreditation

All PPOs made available to enrollees will be required to attain accreditation from the National Committee for Quality Assurance or the Utilization Review Accreditation Commission. Any PPO which does not have the required accreditation will be made available during the next open enrollment only by mutual agreement of the parties.

7. PPO Public Reporting

All PPOs shall be required to publicly report NCQA, URAC, HEDIS and any other data that may be relevant to consumer information needs, unless otherwise mutually agreed to by the parties.

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During these negotiations, the parties reemphasized their commitment for the Company-Union Committee on Health Care Benefits to investigate, consider, and upon mutual agreement, engage in activities that may have high potential for cost savings while achieving the maximum coverage and service for the employees covered for health care benefits for the money spent for such protection. The items to be considered include, but are not limited to, the following:

1. Work with other groups within the Company and the Union, as well as outside organizations, to develop and implement educational and health awareness activities and communications. The costs associated with the development of a communication strategy would be paid through CUCHCB funds.
2. Work with carriers to develop and implement appropriate pilot programs including, but not limited to, lab, imaging and home health care services, to develop relationships with high quality, cost-effective providers and to encourage enrollee use of such providers.

3. Review the experience of the use of “par” and/or contracted provider networks and provisions applicable to reimbursement for physician and other medical providers. Make a determination (based on data supplied by the carriers and other resources) as to whether the provisions are a barrier to delivery of quality and cost-effective care.
4. Commission independent audits of, or conduct bid processes for, the administrators of Program coverages to assure that the highest quality, access, service, professional standards, price/cost and express commitments set forth are maintained. This includes identifying best-in-class administrators of services covered under the Program. The CUCHCB will monitor the administrator’s performance and address any shortcomings with appropriate action up to and including changing carriers.
5. Review the operation of the claims processing systems, and the procedure for review of denied claims, with the objectives of improving the initial adjudication of claims, enhancing enrollee understanding, discouraging filing/processing of inappropriate appeals, eliminating duplication of effort, and facilitating timely resolution of appeals.
6. Work with appropriate carriers to evaluate and modify coverage for injectable medications. Identify appropriate distribution points for injectable medications (for example, via pharmacy or professional provider locations) to promote the safety and efficacy of delivery, appropriateness, and cost effectiveness of injectable medications.

7. The parties will continue to evaluate and implement initiatives related to the use of specialty medications. These initiatives will include, but are not limited to, a specialty drug retail network (to improve enrollee care and achieve better pricing), a program that would address limits on quantity in retail and mail order when enrollees are initiating treatment (to avoid excess cost and potential waste) and the adoption of Rx tools as soon as practicable prior to or after marketing (to ensure appropriate use, enhance medication safety and promote quality for specialty drugs).
8. Review and discuss opportunities for programs that will optimize utilizations of diagnostic radiology services, in particular computerized axial tomography (CAT), magnetic resonance imaging (MRI), and positron emission tomography (PET) scans. In light of evolving technology, utilization increases, and Certificate of Need (CON) erosion and the resulting proliferation of imaging providers, the parties will review tools, programs and opportunities for appropriate controls on diagnostic radiology utilization.
9. The parties will discuss possible changes to the process used to evaluate Pharmacy Quality and Safety Components.
 - The PBM will be encouraged to advance proposals to the parties for consideration, including a detailed explanation and rationale for each proposal. The parties agree to review these proposals quarterly and implement as soon as practicable upon mutual agreement. By the end of 2012, the parties will review the evaluation process through CUCHCB and

determine if there is any further need for an independent pharmacy consultant.

10. The parties will mutually revise the methodology for establishing enrollee contributions for HMOs and PPOs, as outlined in the “Understandings with Respect to Employee Contributions – Health Maintenance Organizations (HMOs).” The revised methodology will account for differences attributable to gender, age and contract size within the enrolled population. The parties will also establish a method to assure that alternative plans are not disadvantaged by the implementation of the restructuring of the Traditional option on a PPO platform (e.g., Traditional Care Network). The parties will mutually establish appropriate thresholds for plan membership and apply the methodology to produce statistically significant results. It is expected that HMOs will provide claims data to enable a health status adjustment to be calculated. HMOs which do not provide such information may no longer be offered if contributions are generated.
11. Explore the potential for including certain over-the-counter medications under the prescription drug coverage of the Program. Any potential change to the coverage would be implemented on a pilot basis, be predicated on there being no tax disadvantages to the Company or enrollees and be discontinued if there are no demonstrable savings to the Program.
12. The parties will review the CUCHCB budget on a quarterly basis.

13. The parties will explore, with other large purchasers, piloting Ambulatory Intensive Care Units (AICUs), with a target pilot implementation in the first quarter of 2013.
14. The parties will explore possible carve-out arrangements for specific benefit areas when competitive pricing and quality delivery can be achieved. Specified carve-out arrangements would be considered for implementation in 2012.
15. The parties will evaluate the merits of approved medical practice regarding the diagnosis and treatment of gambling addiction and, if warranted upon mutual agreement, consider inclusion into the mental health and substance abuse program.
16. The parties agree to investigate the benefits of pain management, hydrotherapy, acupuncture and naturotherapy, and upon mutual agreement, include in the Program.
17. The parties agree to allocate up to \$100,000 in CUCHCB funds for the purposes of encouraging participation in the LifeSteps program.
18. To continue to work jointly with the UAW Retiree Medical Benefits Trust (RMBT), and other entities who may join, to share knowledge and information, consistent with their existing contractual and legal obligations in order to improve health benefits in a way that increases quality, lowers costs, produces less waste, and provides better patient care and outcomes. This joint effort will not create any legal structures or modify in any way any existing contractual rights, financial obligations or relationships.

19. To work jointly with the carriers to evaluate the World Professional Association for Transgender Health (WPATH) standards and upon mutual agreement, include in the Program.

20. During the current negotiations, the parties discussed at length substance use disorder and its prevalence in the workplace and the importance of quality addiction treatment programs. As a result of those discussions, it is agreed that within 90 days of the Company's receipt of notice of ratification of the 2019 UAW-GM National Agreement (the "National Agreement") the national parties will form a pilot team to search for Centers of Excellence working with mutually-agreed upon outside organizations for standards, guidance, support and communications.

General Motors and the UAW believe that their continuing efforts to help employees and their covered dependents obtain post-rehabilitation aftercare treatment and other follow-up care is imperative to improving recovery outcomes related to substance abuse. The Benefit Plans section of the UAW GM Department and the UAW-GM Work/Family Department will work jointly with the Company through the CUCHCB to research and, if mutually agreed upon, implement a Substance Abuse Center of Excellence Pilot Program.

The Substance Abuse Center of Excellence Pilot Program may include additional covered benefits, additional inpatient treatment, and additional outpatient follow up treatment.

If implemented, the Substance Abuse Center of Excellence Pilot Program will be evaluated after two years and if mutually agreed between the

UAW and General Motors, may be included in the Program or discontinued.

Upon mutual agreement, the Committee could engage in joint efforts relating to specific issues in the above areas.

The Company will make available limited funds beginning October 16, 2019 for four years to fund such mutually agreed upon activities as studies, pilot projects, education programs and use of consultants.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During the 1984 negotiations, the parties agreed to the Informed Choice Plan, under which an employee can elect a Health Maintenance Organization option, or a Traditional option. Under those options, enrollees can receive quality health care with benefits equal to those under previous coverage if approved services are obtained in accordance with the provisions of the option selected.

Although adoption of the Informed Choice Plan resulted in improvements to the health care coverage, both in terms of quality of care and cost containment, as discussed during the succeeding negotiations, the parties agreed that continued efforts for improvement are required.

As evidence of their commitment to contain costs under the health care coverage provided, the parties have agreed to intensify their efforts to reduce health care costs in constant dollars (adjusted for inflation in the economy by the overall CPI). The carriers for health care coverage will assume some financial risk in intensifying their efforts to reduce health care costs and

they, in turn, may impose some financial risk on certain providers. It is expected such an arrangement will build upon a similar arrangement agreed to during prior negotiations.

The parties also have agreed that the Control Plan and carriers will continue to be required to provide data and reports with respect to the Informed Choice Plan so as to enable the parties to make appropriate evaluations.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

As discussed during these negotiations, this will confirm our understandings that for purposes of Article IV, Section 10(a) of the Program, the definition of “employee” will include all hourly persons employed by Manual Transmissions of Muncie, LLC, formerly New Venture Gear, Muncie, Indiana.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur
Vice President
GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

This will confirm our intent to discuss, evaluate and implement by mutual agreements certain quality and safety components in the Prescription Drug Coverage. The components listed below are examples that are intended to enhance medication safety and cost effectiveness by improvements founded on best prescribing practices and evidence- based medical guidelines.

- a. Prior Authorization
- b. Step Therapy
- c. Enhanced Digestive Health Solutions
- d. Appropriate Quantities
- e. Dose Optimization
- f. Excess Dose Or Quantity Over Time

The carrier's appeal process for physicians and enrollees will be available.

The parties agree that oversight of these components will be under the Company-Union Committee on Health Care Benefits (CUCHCB). Rx tool proposals will be reviewed on a quarterly basis and, upon mutual agreement, implemented as soon as practicable. The review process for safety-related Rx tools will be expedited to ensure agreed upon tools are implemented quickly to protect the enrollees.

The safety-related Rx Tools presented to the CUCHCB in January 2011 will be implemented as soon as practicable. The parties have agreed that, once implemented, the carrier will provide the CUCHCB a regular (minimum of quarterly) review of the overall program operations and member concerns and make recommendations for improvement.

The parties have agreed to jointly revise the programs when problems arise and modifications are necessary.

Very truly yours,
GENERAL MOTORS LLC
D. Scott Sandefur
Vice President
GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During these negotiations, the parties recognized the need to move ahead with the development of technological applications to improve the quality of service provided to hourly employees.

1. The parties recognize the need to provide the necessary tools to Local Union Benefit Representatives so that they may improve the service they are providing to hourly employees. Local Union Benefit Representatives require basic information that can be accessed quickly in order to confidently and accurately answer many of the questions they receive.
2. The parties further agree that the Company provide Local Union Benefit Representatives with GM On-Line computers with access to the appropriate systems required to perform their duties. The parties agree to provide voice mail, email and/or an answering machine at plant locations.

3. Information of importance to Local Union Benefit Representatives, including but not limited to the Benefits Supplemental Agreements, prescription drug therapy programs, training materials, and information updates will be jointly developed and may also be made available by the Company electronically.
4. The parties further agree to work toward enhancing the information available through Fidelity's Plan Sponsor WebStation® (PSW).
5. The parties further agree ongoing discussions to enhance the information available through the disability administrator's web-based tool to provide Local Union Benefit Representatives and Alternates information regarding leaves of absence.

In conclusion, during the term of the new Agreement, the parties pledge to carefully consider every opportunity to improve the quality and efficiency in benefits delivery.

Very truly yours,
GENERAL MOTORS LLC
D. Scott Sandefur
Vice President
GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During these negotiations, the parties renewed their commitment to provide on-going training programs for Company and Union Benefit Representatives so as to improve the quality of service provided to hourly employees. The parties also recognized the importance of communications programs aimed at educating employees about their benefits.

The Executive Board – Joint Activities will approve the development and implementation of training education programs. Such training education programs will be developed jointly. Funding for such training education programs, including development cost, travel, lodging and wages of participants shall be paid in accordance with the Memorandum of Understanding-Joint Activities. These programs include, but are not limited to, the following:

- Three joint UAW-GM Benefits Training Conferences will be scheduled upon approval by the parties.

- Continuing education program will be revised and updated for Union Benefit Representatives, newly appointed Union Benefit Representatives and Alternates as agreed to by the parties. The sessions will concentrate on areas such as eligibility to receive benefits, description and interpretation of benefit plan provisions, and calculation of benefits.
- Conduct periodic on-site plant surveys and audits to evaluate training and education needs to improve employee service.
- Ad hoc training meetings and materials on legal developments or other special needs.

The Company will pay for lost time (eight hours per day base rate plus COLA) of Union Benefit Representatives attending such programs away from their locations. The Company will also pay for the time (eight hours per day base rate plus COLA) of alternate Union Benefit Representatives who replace those attending such programs.

Very truly yours,
GENERAL MOTORS LLC
D. Scott Sandefur
Vice President
GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During these negotiations, the parties discussed health care management and the importance of providing quality health care in a cost-effective manner. These discussions included the current Integrated Health Management (IHM) program, as well as other activities and Health Care Program components associated with the overall management and coordination of care for enrollees.

Various aspects of the Program that relate to care management have not been evaluated in some time. These include, but are not limited to, pre-determination processes, case management, second surgical opinion and cardiac rehabilitation. These components originated in the 1980s and early 1990s, and have not been evaluated in depth since that time. In addition, tools and approaches to care management have evolved since the time all of these components were implemented. The parties agree that the components do not fully address enrollee needs across the health care continuum or enrollee needs for information regarding health, disease and provider quality. The parties also agree that any office visit

coverages will be subject to applicable co-payments. The current structure of services is in some cases fragmented, could be integrated more effectively, and/or redesigned to create a more integrated, seamless approach to overall medical management.

A dedicated UAW-GM team has been developed and may address the following, including but not limited to:

1. Identifying objective standards which can be applied uniformly in evaluating quality and appropriateness of medical necessity and overall utilization.
2. Identifying utilization review programs and predetermination processes that enhance efficiency and effectiveness of the Program.
3. Evaluating the appropriateness of retaining independent third-party utilization reviewers.
4. Reviewing, evaluating and, if appropriate, adjusting the case management component with respect to the type and identification of cases receiving consideration and the effective use of existing Program coverages prior to development and implementation of Alternative Benefit Plans.
5. Reviewing Program provisions relating to transplant surgeries and other services for which there is a direct relationship between quality of care and the volume of procedures performed such as cardiac and cancer care.
6. Developing relationships with high quality, cost-effective providers and encouraging enrollee use of such providers.

7. Reviewing existing cardiac rehabilitation pilots to evaluate their cost effectiveness and evaluating integrating cardiac rehabilitation with other care management features.
8. Exploring ways of involving patients in treatment decisions, including but not limited to the use of interactive shared decision-making tools.
9. Exploring non-traditional services that may assist in the management of serious health conditions, including treatment that can alleviate chronic debilitating pain and alternate treatment modalities which will enhance recovery during an inpatient admission.
10. Exploring end-of-life care options as an alternative to other medical modalities.
11. Exploring opportunities for linking members to appropriate, approved clinical trials.
12. Evaluating current disease management programs (e.g., CCM) and identifying enhanced programs and methods for increasing enrollee participation as appropriate.

Certain aspects of the new arrangement may be structured with automatic enrollment to improve participation in programs. The Integrated Health Management component may be aligned with the LifeSteps health promotion activities for maximum

Misc. (Integrated Health Management)

impact. Existing carriers will be required to provide data in a timely manner to care management vendors to insure appropriate administration of program components.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

UNDERSTANDINGS WITH RESPECT TO HEALTH CARE – HMO

1. Annual Review of New HMO Offerings

The parties will continue to annually review the possibilities for adding new HMOs to the Program, with the goal of ensuring that enrollees have the opportunity to enroll in HMOs that meet the parties' quality, access, benefit design, cost-effectiveness, and delivery of service requirements. The review will place emphasis on service areas where alternative plans are not presently available, on areas where only one alternative plan is available and on ensuring that the needs of enrollees are addressed. The annual review of new HMO offerings will be conducted in a manner to allow sufficient time to include newly- approved HMOs within the annual enrollment process.

2. HMO Performance

The parties will address the overall performance and continuation of individual HMOs on the basis of quality, access, benefit design, cost-effectiveness, and delivery of services. HMOs, which do not achieve and maintain expected performance levels, or whose costs compare unfavorably to other available options, may be discontinued upon agreement of the parties. Additionally, to the extent that other ongoing HMO performance problems arise during the life of this agreement, the parties agree to discuss these problems in the CUCHCB and to seek resolution.

3. *Mental Health and Substance Abuse Services*

In order to address the parties' concerns over the manner in which mental health and substance abuse services are delivered in certain HMOs, the parties will monitor input from enrollees, providers, carriers, appropriate Union representatives and outside consultants. HMOs will be evaluated in comparison to TCN's mental health and substance abuse care concepts, the National Committee for Quality Assurance (NCQA) Managed Behavioral Health Organization Accreditation Standards, the GM HMO Performance Expectations and other standards agreed to by the parties.

Regardless of the fact that the HMO may be accredited, the parties will work with those HMOs that are not in compliance with the parties' expectations. In the event that an HMO is unable or unwilling to meet the parties' expectations, the parties may, by mutual agreement, assign the mental health and/or substance abuse coverage and services to another carrier. If such a decision is made, it is recognized that prescription drug and other provisions may need to be addressed, to assure that the HMO's enrollees continue to receive the full range of coverage. Alternatively, and also by mutual agreement, the parties may cease to offer the HMO.

4. *HMO Accreditation*

All HMOs made available to enrollees will be required to attain at least provisional accreditation from the NCQA. Any HMO which does not have the required accreditation will not be made available during the next open enrollment, unless offered or retained by mutual agreement of the parties. The parties will monitor the HMOs receiving provisional accreditation to ensure they seek to attain higher accreditation.

5. *HMO Patient Rights*

The parties will request that HMOs communicate to enrollees through direct mailings or otherwise about how they may: obtain coverage and receive care; gain access to other plan services, including referrals outside the plan network; and register complaints and utilize the grievance process. Such communications shall conform to federal and state laws as applicable. The parties may recommend standard formats for providing this type of information. The parties may take such mutually agreed upon steps as they deem appropriate (including termination of the plan offering) should a plan be out of compliance.

6. *HMO Benefit Design*

The parties will continue to review benefits provided by HMOs, in order to ensure adequate compliance with the agreed upon benefit design. Upon mutual agreement of the parties, HMOs will be permitted to offer benefit designs that mirror TCN. HMOs offered to enrollees will provide a full array of preventive services, including appropriate cancer screening services and early detection and screening procedures. In situations where a prescription drug order, for an otherwise covered drug, is written by a dental service provider, or a mental health/substance abuse service provider when such services are carved out, the HMOs will recognize such prescription order as a covered service. The HMOs will be expected to provide coverage for contraceptives as outlined in Appendix A, III.E.3.q. and III.G., at a minimum. In performing the review the parties will look to such items as NCQA accreditation standards, the GM HMO Performance Expectations, the results of site visits and HMO responses on the annual pre-enrollment “long form” benefit report, as well as to enrollee and Union representative feedback.

7. Public Reporting of HMO Data

All HMOs shall be required to publicly report NCQA, HEDIS and any other data that may be relevant to consumer information needs, unless mutually agreed to by the parties.

8. Shared Decision Making

HMOs offered to Program enrollees are encouraged to foster shared decision making between enrollees and physicians, based on full discussion of the benefits and risks of treatment alternatives. The parties have agreed to explore effective ways of involving patients in treatment decisions, including but not limited to the use of interactive decision-making tools, and to implement one or more pilot programs as mutually agreed to by the parties. The parties will decide upon appropriate contractual requirements for HMOs, in order to achieve similar desirable results.

9. Confidentiality of Individually Identifiable Health Care Information

HMOs offered to Program enrollees are required to maintain confidentiality of individually identifiable clinical information, in accordance with the stated Company policies, accreditation requirements and applicable laws.

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

The Company and the Union have agreed on the desirability of maintaining a set of principles concerning the confidentiality of medical information. The Company reviewed with the Union its processes and practices in this regard. The parties acknowledged that medical information, in the context of this letter, means any record, written or electronic, identifying a participant in the UAW/General Motors Hourly-Rate Employees Pension Plan, Life and Disability Benefits Program for Hourly Employees or the Health Care Program for Hourly Employees (collectively, "Benefits Programs"), containing diagnostic or treatment information and used in connection with the administration of the Benefits Programs. Accordingly, the following are understood:

- Participants in the Benefits Programs have a legitimate interest in the confidentiality of medical information pertaining to them.

- The Company, third party administrators, and other parties acting on behalf of the Company or third party administrators in connection with the Benefits Programs (“Other Parties”), have a legitimate need to collect, maintain, and use medical information in the course of performing administrative and other fiduciary functions required by the Benefits Programs and the law (e.g., verifying eligibility and benefit status, claims adjudication, audits for payment purposes, case management, coordination of benefits).
- The Company, third party administrators and Other Parties have a legitimate need to collect, maintain and use aggregate medical information for purposes of analysis, evaluation, oversight and quality control.
- In addition to applicable legal requirements, access to medical information maintained by the Company, third party administrators and Other Parties will be limited to persons having a need to use the information in the course of performing their job duties, and where appropriate and feasible, narrowly tailored in terms of scope and detail to achieve intended business purposes. Aggregate data and/or summaries will be used by the Company to the extent feasible.
- Medical information exchanged with Other Parties for analysis and evaluation will be used and maintained only for the purpose for which it is provided and not re-disclosed by Other Parties without the prior consent of the Company and the Union.

- The Company will establish internal safeguards concerning the exchange of medical information by the Company. Employees who inappropriately exchange medical information will be subject to disciplinary action. The Company will also require third party administrators and Other Parties to establish and enforce policies and procedures consistent with this letter.
- Medical information may be exchanged with Other Parties for clinical, public health and academic research only if a meaningful purpose is to benefit participants in the Benefits Programs. Absent such purpose, the prior agreement of the Company and Union on all aspects of the research (e.g., topics, selection of researchers, distribution of results) is required.

Benefits Programs treatment interventions should not be made by employees of the Company other than its medical personnel in the course of their normal activities.

The Company, in consultation with the Union, is committed to continuing its development of processes and practices regulating the use of medical information within the Company and by third party administrators and Other Parties. In addition, while it is not medical information, the parties will pursue opportunities to reduce reliance on the use of social security numbers as the means of identifying enrollees for purposes of Program Administration.

Misc. (Confidentiality)

Should issues arise during the course of the agreement concerning the confidentiality of medical information, the Company will meet with the Union to discuss mutually agreeable solutions.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During these negotiations, the Company and the Union discussed initiatives presently under consideration at the federal government level to reform the health care delivery system. The proposed reforms include provisions that would impose, among other things, (i) liability on health care plans, employers, employees, agents and other entities for punitive and compensatory damages arising out of the provision of benefits, (ii) requirements for timely decisions of certain benefit claims, (iii) access to external, independent claim reviews, (iv) access to specialty care, and (v) protections for the provider/patient relationship.

The likelihood of any initiatives becoming law is unknown, and the elements and impact of any legislation cannot be predicted. Nonetheless, the parties agreed that if any national health plan reform legislation is enacted during the term of the agreement, the Company and the Union, through the Company-Union Committee on Health Care Benefits, will discuss and implement modifications to the Health Care Benefits Program that comply with federal standards as they become effective. The

compliance effort will also be undertaken in a manner that achieves the following objectives:

- Minimizes litigation risk to the Program and its fiduciaries.
- Provides greater opportunities for participants to resolve denied claims through Program appeal processes.
- Addresses the legitimate concerns of participants in awareness and understanding of health care issues and benefit terms.
- Corrects any Program terms that constitute unintended violations of new legislation.

The parties agreed to meet during the term of the agreement to discuss the status of proposed federal legislation and take measures consistent with this letter to expeditiously address the mutual objectives of the parties.

Very truly yours,
GENERAL MOTORS LLC
D. Scott Sandefur
Vice President
GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During these negotiations, the Company and the Union discussed services designed to assist couples in conceiving and bearing a child and the adequacy of present coverage in light of current and evolving reproductive services technology which may produce better results.

The parties agree that as soon as practicable following the effective date of this Agreement, the Company-Union Committee on Health Care Benefits (CUCHCB) will gather and evaluate data relative to fertility services and determine the feasibility of delivering such services in accordance with the concepts listed below. The parties may consult with experts in the field as they proceed with such investigation, the fees for which will be charged against CUCHCB funds.

The benefit will be designed so that a common treatment approach is achieved, where appropriate. Panel providers will be credentialed who:

Misc. (Fertility Services)

- are qualified in their field;
- agree to abide by a consistent treatment regimen in terms of diagnostic tests, drugs and protocols, where appropriate;
- maintain quality standards; and
- are willing to meet conditions as the parties may require.

Eligibility for services under the fertility coverage may be limited to those received from panel providers. Once a pregnancy has been confirmed, the patient may continue obstetric services with her regular doctor.

To the extent feasible the coverage may be carved out from all plans and centered in a national reproductive services program and done in concert with the Union and their other employer partners.

The coverage may include, but is not necessarily limited to, counseling, treatment for underlying conditions of sexual dysfunction, diagnostic services, pharmaceuticals, artificial insemination, in vitro fertilization, surgical intervention, cryopreservation, transvaginal ultrasound, and donor gamete. The parties may also consider adopting:

- a set number of cycles for services (because of the declining probability of success);
- a maximum number of transfers per cycle (in order to reduce the likelihood of multiple births);
- a number of episodes of treatment that will be covered under the program or otherwise set a frequency limitation.

Based upon the results of the investigation and analysis, the parties may, upon mutual agreement, decide to implement a pilot to test the validity of the concept.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During these negotiations, the Union and the Company conducted extensive discussions regarding ongoing support for bone marrow screening registry programs. The parties share the goal of offering screenings for the Be The Match registry at all UAW-represented GM locations. In order to accomplish this goal, it will be the responsibility of the LifeSteps program to organize bone marrow screening events in conjunction with annual LifeSteps screenings, local plant blood drives and/or in conjunction with a special need that arises at a location (e.g., someone working at the plant who needs an unrelated marrow or blood stem cell donor).

Upon mutual agreement, bone marrow screenings will be funded by the Company. Whenever possible, alternative sources of funding will be sought through the National Marrow Foundation, the National Marrow Donor Program and other entities.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During these negotiations, the parties discussed the nationwide expansion of the UAW-GM health promotion program.

The parties agreed to designate representatives from the GM Department of the UAW International Union Benefits Staff, GM Employee Benefits and, if appropriate, the UAW-GM CHR Health and Safety, to form a Health Promotion Workgroup (the Workgroup) which will be responsible to the Company-Union Committee on Health Care Benefits (CUCHCB).

Among other activities, LifeSteps will focus on reduction of factors which place employees at high risk of disease – high blood pressure, high levels of cholesterol in the blood, excess weight and tobacco use. It also will focus on prevention of the spread of AIDS. Among other tools to be used by the Workgroup are voluntary health assessment questionnaires and risk appraisals to be completed by participating employees and biometric screening as approved by the CUCHCB. The parties have

discussed smoking cessation programs, have acknowledged that such programs are beneficial and agree that the Workgroup should review the effectiveness of such programs in use.

The parties further agreed to the following:

- LifeSteps will be provided to all UAW-represented General Motors locations. LifeSteps will include certain in-plant components (LifeSteps questionnaires, biometric screenings on an annual basis, wellness support classes), as well as the use of the LifeSteps.com website, and other health information tools.
- Dependents of active employees will have access to LifeSteps.com, periodic LifeSteps communications and health information, as well as periodic LifeSteps questionnaires by mail.
- Plant managers will encourage and allow UAW workers at all locations time off the job to participate in a health screening once every year during work hours. The schedule for screenings must be approved by local management, consistent with operational needs and other plant activities.
- Increase involvement with health plans and carriers to avoid redundancies and reinforce health improvement interventions, such as disease management.
- Commit to add a quality vision screening component to the current biometric screening by mutual agreement and develop additional health intervention strategies such as weight loss, nutrition education, exercise programs and

others deemed appropriate by the CUCHCB. Such strategies will be made available to GM locations for implementation. Should the local parties desire to add additional programs, they must obtain approval from the CUCHCB.

- Develop and implement metrics to measure and evaluate the functioning of the entire LifeSteps program on an annual basis.

Any unresolved issues will be addressed by the national parties through the CUCHCB. The CUCHCB will approve the national program specifics and implementation plan, prior to implementation. The LifeSteps program will be paid for by Company funds.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

A nationwide Fitness Center Network will be made available to all UAW active employees and their dependents through medical plan carriers, where available, which will offer discounted membership fees to be paid fully by enrollee. To increase awareness, the parties agreed to promote communication of the available discount program(s) through various means, which may include bulletins, posters, and health fair flyers.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur
Vice President
GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During 2007 negotiations, the parties discussed streamlining the structure of the Appendix B Mental Health and Substance Abuse coverage by consolidating the functions of the Central Diagnostic Referral agencies (CDR), the Central Review Organization (CRO), and the carrier under one vendor. The parties will charge the vendor with the responsibility for encouraging appropriate medical practices, enhancing quality of care and promoting efficient use of resources. Additional vendor goals will be to:

- 1) Ensure enrollees receive high quality, cost-effective services;
- 2) Enhance enrollee servicing;
- 3) Improve pricing;
- 4) Avoid duplication of effort; and
- 5) Ensure the adequacy of mental health networks and specialty providers.

Effective January 1, 2010, the parties agreed to implement a carrier change for Appendix B Mental Health and Substance abuse coverage.

The Company-Union Committee on Health Care Benefits (CUCHCB) will assure that the highest quality, access, service, professional standards and express commitments set forth are maintained. The CUCHCB will monitor the carrier's performance and address any short comings.

During 2015 negotiations the parties reemphasized their commitment to address inefficiencies or gaps in care for those enrollees receiving mental health covered services or substance abuse treatment. The parties will prioritize evaluation of programs addressing the needs of these patients.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

This will confirm our understanding to implement a drug approval process under the prescription drug coverage as soon as practicable following the effective date of this Agreement. This process is intended to identify and evaluate FDA-approved drugs and biologicals for possible exclusion or limitation under the prescription drug coverage of the Health Care Program. The process may focus on medications that offer minimal improvements over existing agents, medications with safety concerns, and high cost medications. The Parties agree some of these products do not offer any innovation or advances in therapy but are higher in price and therefore not adding additional value to the Program.

The Carrier will identify new or existing products which are expected or shown to be of concern. An independent consultant to be jointly selected by the parties will develop recommendations for inclusion, inclusion with limitations or exclusion from the Program. Drugs will be automatically included, unless the parties agree to exclude or limit them, or they are

otherwise excluded under the Program. The Carrier will implement the decisions of the parties with respect to the recommendations.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

This is to confirm the understandings reached between the parties concerning post-employment and survivor health care coverages for new hires. This letter modifies the provisions of Article III, Sections 6 and 8 of the Program, applicable to retirees and survivors, respectively.

For purposes of post-employment health care coverage, “new hire” means

- (a) A UAW-represented employee (other than a Flex Employee) who is on-roll, but who has not attained seniority as of September 14, 2007, and
- (b) A UAW-represented employee (other than a Flex Employee) hired on or after September 15, 2007.

Flex Employees are not eligible for any post-employment or survivor coverage.

Upon retirement (or death), Program coverage will cease at the end of the month last in active service. In lieu of Company contributions for health care coverage in retirement (or for surviving spouse health care coverage), effective October 15, 2007, and continuing during the working career of the new hires, the Company will contribute an amount equal to \$1.00 for every compensated hour into the employee's 401k plan. The parties have agreed to continue to study more efficient methods for delivering this benefit.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

This letter shall confirm our mutual understanding that the parties have agreed to drop all HMOs (excluding Blue Care Network, Health Alliance Plan and Health Plus in the markets these plans are currently offered) and all of the PPO plans, effective January 1, 2008. Any remaining HMOs that are non-performing will be frozen to new enrollment until the HMO becomes performing. In addition, the parties agree to study the feasibility of transitioning the above mentioned HMO plans to a self-insured PPO platform.

Effective January 1, 2008 all enrollees in the affected plans will transition to Traditional Care Network.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During the course of these negotiations, the parties discussed the impact of any pension increases on the retirees and surviving spouses who are currently considered as “protected retirees” under the terms of the settlement agreement approved by the court in the case of Int’l Union, UAW, et. Al. v General Motors Corp., Civil Action No. 05-73991 (the “Settlement Agreement”).

The Union expressed concern over any increases moving retirees and surviving spouses from “protected” status to “general” status due to their Basic Benefit rate increasing above \$33.33 or their Gross Pension Amount increasing above \$8,000 solely due to the pension benefit rate increases negotiated in the 2007 General Motors Hourly-Rate Employees Pension Plan.

As a result of these discussions, the parties agreed that the pension benefit rate increases and the additional annual amounts associated with these increases will not be included in the two-part affordability test. This agreement applies only to the increases negotiated

in the 2007 General Motors Hourly-Rate Employees Pension Plan and does not amend or modify any other provisions of the Settlement Agreement.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

PROCESS FOR APPEALS IN COMPLIANCE WITH THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Pursuant to the Patient Protection and Affordable Care Act (PPACA), effective January 1, 2012, the following modifications are made to the Health Care Program for Hourly Employees, as applicable to active employees and their eligible dependents. If it is later determined, either by amendment, repeal or by judicial determination that the PPACA external review provisions shall no longer apply, then the PPACA external review provisions shall no longer apply, then the process for review of adverse benefit determinations as set forth herein shall become void and immediately preceding. Program provisions regarding appeals of adverse benefit determinations will be reinstated. To the extent the PPACA external review provisions are expanded, modified or otherwise interpreted by regulation, judicial pronouncement or authoritative agency directive such that the process for external review set forth herein is no longer in compliance with PPACA, the Company reserves the right to make required changes or, to the extent compliance is variable, the parties agree to meet and confer to discuss revisions to the process set forth herein to determine the manner by which compliance will be achieved.

The Voluntary Review Process as described in Article I section 6(c) and the Miscellaneous Letter *Voluntary Review Process* is inapplicable to an appeal of a claim for services covered under Appendixes A, B, and C of the Program for those enrolled in a plan that has lost grandfathered status under PPACA, which will instead be subject to the External Appeal Process as outlined below. Such claims are also subject to the Miscellaneous Letter *Process for Possible Conciliation, Accommodation or Compromise of Final Adverse Benefit*

Determinations. The Voluntary Review Process will still be applicable to appeals of eligibility for coverage as well as appeals of services under Appendix D of the Program and for those who are enrolled in a grandfathered plan.

Additionally, the independent review process of a denial of a service, supply, device, or drug therapy, that has been found to be research, experimental, or investigational in the nature will be suspended and any such appeals will go through the External Appeal Process.

External Appeal Process:

For all appeals for services under Appendix A, B, and C of this Program the following External Appeal Process will apply:

1. Standard External Review

(a) After exhausting the Mandatory Appeal Procedure, an enrollee may request an external review of an adverse benefit determination.

(b) The request for review must be filed within four months of receiving notice of a final adverse benefit determination with the applicable carrier, pursuant to the instructions provided in the final determination letter.

(c) The carrier will conduct a preliminary review of the request within five business days of receipt of the request to determine whether:

(1) The enrollee is or was covered under the Program at the time the health care item or service was requested, or in the case of a retrospective review, was covered under the Program at the time the health care item or service was provided;

(2) The adverse benefit determination or final adverse benefit determination does not relate to the enrollee's failure to meet the Program's eligibility requirements;

(3) The enrollee has exhausted the plan's internal appeal process, unless the enrollee is not required to do so; and

(4) The enrollee has provided all the information and forms required to process an external review.

Within one business day of completing the preliminary review, the carrier must issue a written notice to the enrollee. If the request is complete but not eligible for external review, the notice must include the reasons it is not eligible and contact information for the DOL's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notice must describe the information or materials needed to complete the request and the Program must allow the enrollee to perfect the request within the four-month filing period, or 48 hours after receipt of the notice, whichever is later.

(d) If the carrier determines that the request is eligible for external review, it will assign the appeal to an Independent Review Organization (IRO). The carriers are required to contract with a minimum of three IROs and rotate appeals among them.

The IRO will timely notify the enrollee in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the enrollee may submit, within 10 business days,

additional information in writing that the IRO must consider.

The assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Program's internal claims and appeals process.

Within one business day of making its decision, the IRO must notify the enrollee and the Program.

The IRO must provide written notice of the final external review to the enrollee and the Program within 45 days of receiving the request for external review.

(e) Upon receipt of a notice of a final external review decision, reversing the final internal adverse benefit determination, the Program must immediately provide coverage or payment for the claim, including immediately authorizing or immediately paying benefits.

2. Expedited External Review Procedures

(a) An enrollee may make a request for an expedited external review by contacting the applicable carrier.

(1) After receiving an adverse benefit determination if the timeframe for a standard review would seriously jeopardize the health or life of the enrollee or would jeopardize the enrollee's ability to regain maximum function and the enrollee has filed a request for an expedited mandatory appeal; or

(2) After a final adverse determination, if the enrollee has a medical condition where

the timeframe for a standard review would seriously jeopardize the health or life of the enrollee, would jeopardize the enrollee's ability to regain maximum function involves an admission, availability of care, continued stay, or health care item or service for which the enrollee has received emergency services, but has not been discharged from a facility.

(b) The carrier must determine whether the request meets the standards for an external review immediately upon receiving the request for expedited external review. It must also immediately send a notice to the enrollee of its determination regarding eligibility for review.

(c) If the carrier determines that the request is eligible for external review, it will assign an IRO in accordance with the standard external review requirements. The Program must provide all necessary documents and information related to the claim to the assigned IRO electronically or by telephone or fax or any other available expeditious method. The assigned IRO must consider any information that is available and appropriate under the procedures for standard review. The assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Program's internal claims and appeals process.

(d) The IRO must notify the enrollee of the final external review decision as expeditiously the enrollee's medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the IRO must provide written confirmation of the decision to the enrollee and the Program within 48 hours of providing the initial notice.

PREVENTIVE SERVICES AND MEDICATIONS IN COMPLIANCE WITH THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Pursuant to the Patient Protection and Affordable Care Act (PPACA), effective January 1, 2012, the following modifications are made to the Health Care Program for Hourly Employees, as applicable to active employees and their eligible dependents. Although, PPACA only requires these modifications for health care plans that have lost grandfathered status, the parties agree to also apply the modifications in this letter to the GM Temporary Employee Health Care Plan. If it is later determined, either by amendment, repeal or by judicial determination that any PPACA preventive services and medications provisions as set forth in PPACA section 2713 shall no longer apply, then the parties will include these preventive services and medications under Appendix A. To the extent the PPACA preventive services and medications provisions are expanded, modified or otherwise interpreted by regulation, judicial pronouncement or authoritative agency directive such that the required coverage of preventive services and medications set forth herein is no longer in compliance with PPACA, the Company reserves the right to make required changes or, to the extent compliance is variable, the parties agree to meet and confer to discuss revisions set forth herein to determine the manner by which compliance will be achieved.

A. These preventive services are provided under Appendix A and are also subject to the conditions outlined in Appendix A. III.E.3.n.

(1) Well Baby / Well Child Care: Coverage is provided for:

(a) up to five (5) Well Baby visits for children from 13 months of age through 35 months of age;

- (b) one (1) Well Child visit per calendar year for children from 36 months of age through age 17.
- (2) Routine Physical Examinations: One routine physical examination per calendar year is covered for enrollees age 18 and older.
- (3) Routine Gynecological Examinations: Coverage for one routine gynecological examination per female enrollee per calendar year.
- (4) Cholesterol screening for children age 24 months to 21 years; men over age 35 or age 20-35 if at increased risk for coronary heart disease; women over age 20 if at increased risk for coronary heart disease.
- (5) Certain lab services for certain enrollees as required by PPACA, which include but are not limited to hematocrit, hemoglobin, lead, and tuberculin test.
- (6) One per lifetime, abdominal aortic aneurysm by ultrasound screening including technical and professional component per male enrollee age 65-75, with a history of smoking, pursuant to carrier standards.
- (7) One every two (2) calendar years, osteoporosis screening for female enrollees age 65 and over or at age 60 if risk factors are present.
- (8) Screening for lung cancer with low-dose computed tomography for enrollees age 55- 80 once per calendar year.
- (9) Exercise or physical therapy to prevent falls for community-dwelling enrollees age 65 and older who are at increased risk for falls, once per calendar year.

(10) Diabetes screening for type 2 diabetes in asymptomatic enrollees with sustained blood pressure greater than 135/80 mm Hg twice per calendar year.

(11) Prenatal Screenings as follows:

(a) Asymptomatic bacteriuria screening at 12-16 weeks of gestation once per pregnancy during prenatal visit;

(b) Chlamydia screening once per pregnancy during prenatal visit for female enrollees age 24 or younger or age 25 and older if at increased risk;

(c) Gonorrhea screening once per pregnancy during prenatal visit;

(d) Hepatitis B screening once per pregnancy during prenatal visit;

(e) Iron deficiency anemia screening once per pregnancy during prenatal visit;

(f) Gestational diabetes mellitus screening after 24 weeks of gestation once per pregnancy during prenatal visit;

(g) Prenatal pediatrician visit once per pregnancy;

(h) Rh(d) incompatibility screening twice per pregnancy during prenatal visit; and

(i) Syphilis screening once per pregnancy during prenatal visit.

(12) Infectious disease screenings as follows:

(a) Chlamydia screening once per calendar year for children and young adults age 11 through 21 and adult female enrollees age 24 or younger or age 25 and older if at increased risk;

(b) Gonorrhea screening once per calendar year for children and young adults age 11 through 21 and for adult female enrollees at any age;

(c) Hepatitis B screening once per calendar year for enrollees any age;

(d) HIV screening once per calendar year for enrollees any age; and

(e) Syphilis screening once per calendar year for enrollees any age.

(13) Consultations as follows:

(a) Alcohol misuse screening and consultation, as needed, enrollees any age;

(b) Breastfeeding consultation, twice per calendar year for females and pregnant females, any age;

(c) Obesity consultation for enrollees any age, pursuant to carrier standards;

(d) Healthy diet consultation, six visits per calendar year for enrollees any age with hyperlipidemia, coronary artery disease, diet-related chronic disease or obesity;

(e) Tobacco use and diseases caused by tobacco use consultation, as needed, for pregnant females and adults age 18 and over;

(f) Skin cancer behavioral consultation for enrollees age 10-24 once per calendar year;

(g) Contraceptive use consultation for female enrollees with reproductive capacity twice per calendar year; and

(h) Domestic violence consultation for enrollees of any age once per calendar year.

(14) Hearing loss screening, which is a brief evaluation and is not a complete hearing examination, for newborn through age 21 once per calendar year.

(15) Vision screening, which is a brief evaluation and is not a complete eye examination, for newborn through age 21 once per calendar year.

(16) Visual acuity screening for children younger than five years of age to detect amblyopia, strabismus and defects in visual acuity.

(17) Developmental screening for newborn through age 30 months; two (2) per calendar year.

(18) Intimate partner violence screening for female enrollees of any age once per calendar year.

(19) High-risk human papillomavirus DNA testing for female enrollees of any age once per calendar year.

(20) Anesthesia for contraceptive surgeries for adult enrollees once per calendar year.

(21) Newborn heritable disease screenings, once between birth and age two (2) months.

(22) Newborn Screenings and Prevention

(a) At birth, one screening for each of the following:

(i) Congenital Hypothyroidism

(ii) Metabolic/Hemoglobin

(iii) Phenylketonuria (PKU)

(iv) Sickle Cell Disease

(b) Prophylactic topical ocular medication for gonorrhea for newborns, one dose.

B. The following preventive services could also be performed during an enrollee's routine physical examination. In this situation, these preventive services are covered as part of the routine physical examination and not separate billable items per the carrier:

- Anticipatory guidance
- Alcohol and drug use assessment
- Counseling for aspirin to prevent cardiovascular disease (men ages 45-79; women ages 55 -79)
- Autism screening at ages 18 & 24 months
- Blood pressure screening
- Depression screening
- Developmental surveillance (newborn through age 21)
- Oral health evaluation and dental caries prevention for children through age 5 (evaluate water source for sufficient fluoride, if deficient, prescribe oral fluoride)
- Discussion of folic acid (women, through age 50, who are pregnant or who are planning to become pregnant)
- Iron deficiency anemia screening for ages 6 to 12 months (prescribe iron supplement if deficient)
- Obesity screening
- Discussion of breast and ovarian cancer susceptibility/referral for counseling related to BRCA1/BRCA2 test (females at risk)
- Discussion of chemoprevention when at risk for breast cancer (females at risk)

- Psychosocial/behavioral assessment
 - Sexually transmitted infection education, if sexually active
 - Tobacco use screening (referral for tobacco cessation counseling or prescribe tobacco cessation medications as needed)
- C. The following preventive medications are covered at no co-payment, subject to carrier standards, and are exempt from deductibles, co-payments or co-insurance, and out-of-pocket maximums that might otherwise apply. The medications are required to have a prescription order and must be dispensed by a participating mail or retail pharmacy:
- Aspirin
 - Fluoride
 - Iron supplements
 - Tobacco cessation products
 - Folic acid
 - Vitamin D supplementation for community-dwelling enrollees age 65 and older
 - Breast cancer primary prevention medications prescribed for prevention of invasive breast cancer in female enrollees at high risk who do not have a prior history of a diagnosis of breast cancer, age 35 or older
 - Oral and other contraceptive methods for female enrollees of reproductive capacity

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During these negotiations, the parties discussed the Patient Protection and Affordable Care Act (PPACA) mandatory external review process applicable to a final adverse benefit determination from the last level of the internal claims and appeal process under the General Motors Health Care Program for Hourly-Rate Employees. The parties discussed that after a final adverse benefit determination, the parties may benefit by engaging in a dialogue toward possible compromise, conciliation or accommodation that may obviate the time, expense and inconvenience associated with external review.

Therefore, the parties agreed that with respect to claims susceptible to mandatory external review, after a final adverse benefit determination but before the issuance of a final decision by the Independent Review Organization (“IRO”) and upon a request from the Union, the parties will engage in discussions toward possible compromise, conciliation or accommodation of the claim. Upon request by the Union or a union benefit representative, the Company, Control Plan, or carrier will provide information material to the

adverse benefit determination and advise what would be needed in order to support the employee's claim for payment of benefits. Other than described above, nothing in this agreement requires that the parties follow any specific procedures when exploring possibilities for compromise, conciliation or accommodation and nothing in this agreement requires either party to modify their respective positions with respect to a claim. Furthermore, that the parties engage in discussions pursuant to this process shall not toll any time limits applicable to any such claim and a refusal by GM to conciliate, accommodate, or compromise a final adverse benefit determination pending IRO decision shall not be deemed to constitute an adverse benefit determination with respect to said claim.

This agreement is conditional upon the parties' understanding that engaging in this process does not constitute a voluntary internal review to which the PPACA mandatory external review process applies. To the extent it is later determined by a court of competent jurisdiction, by regulatory or statutory amendment or by the issuance of authoritative

Misc. (Process for Possible Conciliation, Accommodation or
Compromise of Final Adverse Benefit Determinations)

guidance by governing agencies that this process does
constitute a voluntary internal review process, this
letter agreement shall become null and void.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

During these negotiations, the parties discussed the application of the Excise Tax on High Cost Employer-Sponsored Health Coverage imposed under the Affordable Care Act on any health plans an employer offers. The parties also discussed that the per-employee dollar limits for these high cost health plans may be modified from time-to-time by the federal government.

Should any Health Care Plan offered by the Company be expected to exceed the government mandated per-employee dollar limits and be subject to this Excise Tax, the parties will employ a process similar to that used in Misc. Letter (Supplemental Methodology – Alternative Plans) to find areas of opportunity to reduce cost. The parties further agree that a member who voluntarily remains in such plan will be subject to a maximum deductible of \$400 for single coverage and \$800 for family. Further, the Company will consult

Misc. (Excise Tax Implications)

with the UAW National GM Department to ensure that the Excise Tax calculation is conducted in a manner that results in the lowest tax allowable under the law.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

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WORKERS OF AMERICA, UAW

By: Terry Dittes

GENERAL MOTORS LLC

October 16, 2019

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America, UAW
8000 East Jefferson Avenue
Detroit, Michigan 48214

Attention: Mr. Terry Dittes
Vice President and Director
General Motors Department

Dear Mr. Dittes:

As discussed during negotiations, the parties agreed to remove all benefit plan provisions providing eligibility for same-sex domestic partners and their children due to the recent Supreme Court decision in Obergefell v. Hodges legalizing same-sex marriage throughout the United States, which eliminated the need for such provisions.

The GM benefit plans have historically provided eligibility for same-sex domestic partners in jurisdictions that did not recognize same-sex marriage. Should the Obergefell decision be overruled or revised, the parties agree that they will meet to assure that same-sex domestic partners and their children continue to be eligible for coverage as they had in the 2011 benefit plan agreements prior to the Obergefell v. Hodges decision.

The parties also discussed that same-sex domestic partners and their children would be treated as dependents as defined in the 2011 Supplemental Agreements covering the Benefit Plans between the UAW and GM until December 31, 2016. The parties agree that if issues arise that cause it to be necessary to extend such date, the date will be extended to June 30, 2017 or other mutually agreeable date. With respect to Dependent Life Insurance and or Survivor Income Benefit Insurance (SIBI), such agreement will include incurred claims related to deaths that occurred through and including either December 31, 2016 or June 30, 2017, as applicable. With respect to the Health Care Program, such agreement will include incurred claims that occurred through and including either December 31, 2016 or June 30, 2017, as applicable.

In addition, in the event of the primary enrollee's death, through and including either December 31, 2016 or June 30, 2017, a surviving domestic partner will be provided continuation opportunities comparable to a similarly situated surviving spouse. Under no circumstances will the privileges afforded a domestic partner exceed those of a similarly situated spouse.

Employees who are having their wages grossed up to compensate for imputed income on the value of health care for their same-sex domestic partner coverage will continue to have their wages grossed up until December 31, 2016 or June 30, 2017, as appropriate.

The benefit plans impacted by this agreement include the Pension Plan, Life and Disability Benefits Program, Health Care Program, Profit Sharing Plan, Personal Savings Plan, Supplemental Unemployment Benefit Plan Section, Dependent Care Reimbursement Plan, and Flexible Spending Account Health Care Reimbursement Plan.

Very truly yours,

GENERAL MOTORS LLC

D. Scott Sandefur

Vice President

GMNA Labor Relations

Accepted and Approved:

INTERNATIONAL UNION,
UNITED AUTOMOBILE, AEROSPACE
AND AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA, UAW

By: Terry Dittes

ALLIED UNION SERVICES

