UAW RETIREE MEDICAL BENEFITS TRUST

UAW CHRYSLER RETIREES MEDICAL BENEFITS PLAN
PLAN DOCUMENT

2023

TABLE OF CONTENTS

ARTICLE I - INTRODUCTION 1
SECTION 1.1 PURPOSE 1
SECTION 1.2 PLANS COVERED BY THIS PLAN DOCUMENT 1
SECTION 1.3 ERISA STATUS 2
SECTION 1.4 INCORPORATION OF TRUST AGREEMENT, SCHEDULE OF BENEFITS, SUMMARY PLAN DESCRIPTION, HEALTH CARE BENEFIT HIGHLIGHT LETTER(S), HEALTH CARE BENEFIT SUMMARY, AND INSURANCE POLICIES OR CONTRACTS 2
SECTION 1.5 CONTRIBUTION SOURCE 3
ARTICLE II - ELIGIBILITY, ENROLLMENT, AND PARTICIPATION 4
SECTION 2.1 GENERAL INFORMATION 4
SECTION 2.2 APPLICABILITY OF STATE LAW 4
SECTION 2.3 ENROLLMENT AND CONTRIBUTION PROCEDURES 5
SECTION 2.4 CONTINUED COVERAGE 5
SECTION 2.5 TERMINATION OF COVERAGE 5
SECTION 2.6 COVERAGE HISTORY NOTICE 5
SECTION 2.7 QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) 6
ARTICLE III - PLAN OPTIONS AND BENEFITS 7
SECTION 3.1 FULLY INSURED BENEFIT PROGRAM OPTIONS 7
SECTION 3.2 BENEFITS OF FULLY INSURED BENEFIT PROGRAMS 8
SECTION 3.3 SELF-FUNDED BENEFIT PROGRAM OPTIONS 8
SECTION 3.4 COMPREHENSIVE BENEFIT RULES 9
SECTION 3.5 REFUNDS AND SIMILAR PAYMENTS 10
ARTICLE IV - COORDINATION OF BENEFITS 11
SECTION 4.1 GENERAL 11
SECTION 4.2 APPLICABILITY 11
SECTION 4.3 PAYMENT OF BENEFITS 11
SECTION 4.4 FACILITY OF PAYMENT 12
SECTION 4.5 ORDER OF BENEFIT PAYMENT 12
ARTICLE V - SUBROGATION FOR SELF-FUNDED BENEFIT PROGRAMS 14

ARTICLE VI - CLAIMS AND APPEALS PROCEDURES 16

SECTION 6.1 CLAIMS AND APPEALS FOR FULLY INSURED BENEFIT PROGRAMS AND MEDICARE PART D PRESCRIPTION DRUG PLANS 16

SECTION 6.2 CLAIMS AND APPEALS FOR MOST SELF-FUNDED BENEFIT PROGRAMS (EXCEPT FOR MEDICARE PART D PRESCRIPTION DRUG PLANS) 16

ARTICLE VII - PLAN AMENDMENT OR TERMINATION 19

SECTION 7.1 PLAN AMENDMENT OR TERMINATION OF THE TRUST 19

SECTION 7.2 PAYMENT OF BENEFITS ON PLAN TERMINATION 19

SECTION 7.3 SUMMARY OF PLAN PROVISIONS UPON TERMINATION OF THE TRUST 20

SECTION 7.4 PUBLIC HEALTH AND SIMILAR EMERGENCIES 20

ARTICLE VIII - USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) 21

SECTION 8.1 THE PLAN'S USE AND DISCLOSURE OF PHI 21

SECTION 8.2 THE COMMITTEE'S USE AND DISCLOSURE OF PHI 21

SECTION 8.3 COMPLIANCE WITH THE HIPAA SECURITY RULE 22

ARTICLE IX - GENERAL PROVISIONS 23

SECTION 9.1 GOVERNING LAW 23

SECTION 9.2 SEVERABILITY CLAUSE AND CONFORMITY WITH THE LAW 23

SECTION 9.3 EXAMINATIONS 23

SECTION 9.4 WORKERS' COMPENSATION NOT AFFECTED 23

SECTION 9.5 RELEASE OF INFORMATION 23

SECTION 9.6 RIGHT TO RECOVERY 24

SECTION 9.7 LEGAL ACTION BY AN ENROLLEE 24

SECTION 9.8 MISREPRESENTATION OR FALSIFICATION 25

SECTION 9.9 WORD USAGE 25

SECTION 9.10 HEADINGS 25

SECTION 9.11 CHANGES IN LAWS AND/OR REGULATIONS 25

SECTION 9.12 PAYMENT OF BENEFITS 26

ARTICLE X - PLAN ADMINISTRATION 27

SECTION 10.1 COMMITTEE AUTHORITY AND INTERPRETATION 27

SECTION 10.2 ROLE OF CARRIER 27

SECTION 10.3 INFORMATION ABOUT THE TRUST AND THE PLAN 27

SECTION 10.4 HOW BENEFITS ARE FUNDED 29

ARTICLE XI - DEFINITIONS 30
SECTION 11.1 ADVERSE BENEFIT DETERMINATION 30
SECTION 11.2 ATTACHMENT(S) 30
SECTION 11.3 AUTHORIZED REPRESENTATIVE 30
SECTION 11.4 CARRIER 31
SECTION 11.5 CLAIM 31
SECTION 11.6 CLAIMANT 31
SECTION 11.7 COBRA 31
SECTION 11.8 COMMITTEE 31
SECTION 11.9 DAY(S) 31
SECTION 11.10 DEPENDENT(S) 31
SECTION 11.11 DEPENDENT CHILD (DEPENDENT CHILDREN) 32
SECTION 11.12 ECP OR ENHANCED CARE PREFERRED PROVIDER ORGANIZATION 32
SECTION 11.13 ENROLLEE 32
SECTION 11.14 ERISA 32
SECTION 11.15 EXPERIMENTAL AND/OR INVESTIGATIONAL 32
SECTION 11.16 FDA 33
SECTION 11.17 FULLY INSURED BENEFIT PROGRAMS 33
SECTION 11.18 HEALTH CARE BENEFIT HIGHLIGHT LETTER(S) 33
SECTION 11.19 HEALTH CARE BENEFIT SUMMARY 33
SECTION 11.20 HIPAA 33
SECTION 11.21 HMO OR HEALTH MAINTENANCE ORGANIZATION 33
SECTION 11.22 HOSPITAL 33
SECTION 11.23 INFORMAL ENROLLEE COMMUNICATIONS 34
SECTION 11.24 IN-NETWORK PROVIDERS 34
SECTION 11.25 MEDICALLY NECESSARY (MEDICAL NECESSITY) 34
SECTION 11.26 MEDICARE 34
SECTION 11.27 MEDICARE ADVANTAGE OR MA PLAN 35
SECTION 11.28 MEDICARE ADVANTAGE PRESCRIPTION DRUG OR MA-PD PLAN 35
SECTION 11.29 OUT-OF-NETWORK PROVIDERS 35
SECTION 11.30 PHI OR PROTECTED HEALTH INFORMATION 35
SECTION 11.31 PHYSICIAN 35
SECTION 11.32 PLAN 36
SECTION 11.33 PLAN YEAR 36

SECTION 11.34 PPO OR PREFERRED PROVIDER ORGANIZATION 36
SECTION 11.35 PRIMARY ENROLLEE 36
SECTION 11.36 PROTECTED 36
SECTION 11.37 PROVIDER 37
SECTION 11.38 RETIREE 37
SECTION 11.39 RETIREE HEALTH CARE CONNECT 37
SECTION 11.40 SCHEDULE OF BENEFITS 37
SECTION 11.41 SELF-FUNDED BENEFIT PROGRAMS 37
SECTION 11.42 SPOUSE 38
SECTION 11.43 SUMMARY PLAN DESCRIPTION 38
SECTION 11.44 TCN OR TRADITIONAL CARE NETWORK 38
SECTION 11.45 TRUST 38
SECTION 11.46 UAW 38
SECTION 11.47 UNITED STATES OR U.S. 38
SECTION 11.48 URGENT CARE 38
SECTION 11.49 VEBA 38
EXHIBIT A: INSURANCE CONTRACTS AND OTHER BENEFIT SUMMARIES 39

ARTICLE I - INTRODUCTION

Generally, when terms are capitalized in the Plan Document, they have the meaning set forth in Article XI of this Plan Document.

SECTION 1.1 PURPOSE

The Committee for the UAW Retiree Medical Benefits Trust (the "Trust"), acting on behalf of the Employees' Beneficiary Association ("EBA") for certain UAW represented Chrysler Group LLC Retirees, has established a welfare benefit plan for the eligible Retirees and their survivors of Chrysler Group LLC hereunder that shall be known as the UAW Chrysler Retirees Medical Benefits Plan (the "Plan"). This Plan document is adopted by the Committee of the Trust under the terms of the Trust Agreement. The Plan is a single-employer employee benefit plan as provided under ERISA § 402 and a welfare plan as defined under ERISA § 3. The Plan was originally established as of January 1, 2010, may be amended from time to time, and is maintained in accordance with the provisions of the UAW Retiree Medical Benefits Trust Agreement effective December 3, 2009 (originally effective October 16, 2008), as amended (the "Trust Agreement"). The purpose of the Plan is to provide health and welfare benefits to eligible Retirees, their Dependents, and their survivors. The purpose of this Plan Document is to provide a description of how the Plan operates, its terms, and certain benefits provided under the Plan.

SECTION 1.2 PLANS COVERED BY THIS PLAN DOCUMENT

Enrollees of the Plan have different benefit program options. Some are Self-Funded Benefit Programs, which are funded by the Trust, and some are Fully Insured Benefit Programs, which are funded by the applicable Carriers. The benefit programs available to each Enrollee depends on the Enrollee's location, whether the Enrollee is enrolled in Medicare, and other relevant factors. The Plan provides benefits through the following benefit programs:

1.2. Non-Medicare Benefit Programs

(a) Medical Benefit Programs:

(1) Enhanced Care Preferred Provider Organization ("ECP");

(2) Health Maintenance Organization ("HMO");

1.2.2 Medicare Benefit Programs

(a) Medical Benefit Programs:

(1) Medicare Advantage HMO;

(2) Medicare Advantage Prescription Drug ("MA-PD") HMO or Preferred Provider Organization ("PPO").

(3) Traditional Care Network ("TCN").

1.2.3 Benefit Programs for both Medicare and Non-Medicare

(a) Prescription Drug;

(b) Dental;

(c) Vision;

(d) Hearing;

(e) Over-the-Counter Benefit (note: this benefit is not available for the non-Medicare HMO benefit program).

For Fully Insured Benefit Programs, each benefit program is summarized in an insurance contract provided by the Carrier that the Committee or its delegate has contracted with to provide Plan benefits (and also set forth as an Attachment in Exhibit A of this Plan Document). For Self-Funded Benefit Programs, some are summarized in a benefit summary (and also set forth as an Attachment in Exhibit A of this Plan Document) and other Self-Funded Benefit Programs are summarized in Article III of this Plan Document. The benefits for all benefit programs are also summarized in the Summary Plan Description.

SECTION 1.3 ERISA STATUS

The Plan provides benefits that are subject to the requirements of ERISA. This Plan Document and its Attachments, Summary Plan Description, Schedule of Benefits, Health Care Benefit Highlight Letter(s), Health Care Benefit Summary, and applicable benefit booklets constitute the written plan document required by ERISA §402. This Plan Document has been adopted by the Committee for the Trust under the terms of the Trust Agreement.

SECTION 1.4 INCORPORATION OF TRUST AGREEMENT, SCHEDULE OF BENEFITS, SUMMARY PLAN DESCRIPTION, HEALTH CARE BENEFIT HIGHLIGHT LETTER(S), HEALTH CARE BENEFIT SUMMARY, AND INSURANCE POLICIES OR CONTRACTS

This Plan Document incorporates the Trust Agreement to fully describe the operation of the Plan and the benefits provided by the Plan. In addition, the Plan incorporates the Schedule of Benefits that is currently in effect, as adopted by the Committee, the Summary Plan Description currently in effect, the Health Care Benefit Highlight Letter(s), Health Care Benefit Summary, and the insurance contracts and benefit summaries set forth as Attachments in Exhibit A of this Plan Document. Any insurance policy or contract obtained by the Committee or its delegate solely to provide benefits for Retirees residing outside of the United States is also incorporated into the Plan, but any Plan provisions required solely by United States law (e.g., ERISA) shall not apply to such policy or contract.

In the event of a conflict or inconsistency between the Trust Agreement and the Plan Document, the Trust Agreement controls. In the event of a conflict between this Plan

Document and the Health Care Benefit Highlight Letter(s), the annual Health Care Benefit Highlight Letter(s) controls. In the event of a conflict between this Plan Document and the Health Care Benefit Summary, the Health Care Benefit Summary controls. In the event of a conflict between this Plan Document and the Summary Plan Description, this Plan Document controls. For Fully Insured Benefit Programs, in the event of a conflict or inconsistency between this Plan Document and the Attachments set forth in Exhibit A or Informal Enrollee Communications, this Plan Document controls. For Self-Funded Benefit Programs, in the event of a conflict between this Plan Document and the Schedule of Benefits or Informal Enrollee Communications, this Plan Document controls. For both Fully Insured Benefit Programs and Self-Funded Benefit Programs, silence in an insurance contract, Plan Document, or other governing document on a given topic is not a conflict or inconsistency.

SECTION 1.5 CONTRIBUTION SOURCE

Plan benefits described in this booklet are provided through a Voluntary Employees' Beneficiary Association Trust funded through contributions as established pursuant to court-approved settlement agreements between the Auto Companies and the UAW and the Trust Agreement.

The Committee, on behalf of three separate employees' beneficiary associations (EBA), the Chrysler Retiree EBA, the Ford Retiree EBA, and the GM Retiree EBA, has created three separate retiree accounts. Each separate retiree account is a dedicated account to be used for the sole purpose of funding benefits to eligible Retirees and their Dependents in the respective EBA and defraying the expenses of that account. While the Trust assets are pooled for investment and administrative purposes, the assets attributable to any one separate retiree account may not offset liabilities or defray the expenses attributable to any other retiree account.

Contributions from Retirees and surviving Dependents may be required for participation in the Plan. Benefits are either self-funded and paid out of the Trust's assets or fully insured and paid under an insurance policy between the Trust and a Carrier.

ARTICLE II - ELIGIBILITY, ENROLLMENT, AND PARTICIPATION

SECTION 2.1 GENERAL INFORMATION

A Retiree begins participating in the Plan upon his or her enrollment in a benefit program in accordance with the terms and conditions established for that benefit program. A Dependent, such as a Spouse, same-sex domestic partner, or child, may be eligible to participate in a benefit program under the Plan because of their relationship with the Primary Enrollee. Information about the eligibility, enrollment, and participation terms and conditions of the Plan is set forth in the Summary Plan Description and, for Fully Insured Benefit Programs, in the applicable insurance contract set forth as an Attachment in Exhibit A of this Plan Document.

In order for a Primary Enrollee to add a Dependent to his or her benefit program coverage under the Plan and at such other times as the Plan may determine, the Plan may require the Primary Enrollee to submit proof of eligibility documentation. In such event, the Primary Enrollee must submit the requested proof of eligibility documentation, which could include, but is not limited to, copies of marriage certificates, driver's licenses, the front page of federal income tax returns, court orders (all pages), social security number(s) and signed affidavits. If a Primary Enrollee fails to timely provide all proof of eligibility documentation requested by the Plan, the Plan may cancel a Dependent's coverage or deny a request to enroll an individual as a Dependent in a benefit program under the Plan.

All Retirees and their Dependents must be enrolled in Medicare Part A when first eligible or entitled. This will not apply to any Enrollee who first becomes eligible for Medicare Part A before January 1, 2017.

SECTION 2.2 APPLICABILITY OF STATE LAW

For Enrollees enrolled in Self-Funded Benefit Programs, state laws are preempted, and no state law-based mandated benefit or benefit design applies.

For Enrollees enrolled in Fully Insured Benefit Programs, the Plan will provide benefits to Enrollees as required by applicable state law. Notwithstanding the foregoing, an individual shall be eligible for coverage under the Plan in accordance with the terms and conditions of the Plan, without regard to any state law or insurance policy or contract provision to the contrary.

SECTION 2.3 ENROLLMENT AND CONTRIBUTION PROCEDURES

2.3.1 Effect of Incarceration

Generally, depending upon the location of incarceration, county, state, or federal government authorities are the primary payer of health care expenses, and the Plan will be the secondary payer.

SECTION 2.4 CONTINUED COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a law that allows Retirees and eligible Dependents to purchase continuation coverage under the Plan for a temporary period of time if the eligible Enrollee's coverage under the Plan ends because of certain "qualifying events" specified in COBRA (including but not limited to a divorce from the Retiree, death of the Retiree, or a child no longer meeting the definition of a Dependent). COBRA rights are explained in detail in the insurance contracts and benefit summaries set forth as Attachments in Exhibit A of this Plan Document and the summary of COBRA continuation coverage rights provided in the Summary Plan Description.

SECTION 2.5 TERMINATION OF COVERAGE

2.5.1 Primary Enrollee's Participation Terminates

When a Primary Enrollee's participation in the Plan terminates, benefits under the Plan for the Primary Enrollee and his or her Dependents will cease. Generally, when a Primary Enrollee's participation in a benefit program under the Plan terminates, benefits under that benefit program for the Primary Enrollee and his or her Dependents will cease. Termination of participation in a benefit program occurs in accordance with the terms and conditions established for that benefit program.

2.5.2 Trust or Plan Terminates

Benefits under all benefit programs for all Enrollees will cease upon the termination of the Plan or the Trust.

2.5.3 Other Circumstances Resulting in Termination

Other circumstances can result in the termination of benefits. The insurance contracts and benefit summaries set forth as Attachments in Exhibit A of this Plan Document, Summary Plan Description, Schedule of Benefits, Health Care Benefit Highlight Letter(s), Health Care Benefit Summary, and applicable benefit booklets provide additional information.

SECTION 2.6 COVERAGE HISTORY NOTICE

When an Enrollee's coverage under the Plan ends, Retiree Health Care Connect will provide such former Enrollee with a Coverage History Notice that indicates the period of time the former Enrollee was covered under the Plan. The certificate will be sent by first class mail

within 45 days after the former Enrollee's coverage under the Plan ends. If a former Enrollee elects continuation coverage under COBRA or the Plan, another Coverage History Notice will be provided within 60 days after the continuation coverage ends. In addition, a Coverage History Notice will be provided within 45 days after Retiree Health Care Connect receives a request for such certificate if the request is received within two years after the later of the end of the former Enrollee's coverage under the Plan or the end of the former Enrollee's continuation coverage under COBRA or the Plan.

SECTION 2.7 QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

After a child support order is received by Retiree Health Care Connect, the Plan will determine whether the order is a QMCSO pursuant to the Plan's written procedures, which are available free of charge by making a request to Retiree Health Care Connect. The Plan will notify the Primary Enrollee and the custodial parent of its determination. The Plan will provide benefits in accordance with the applicable requirements of any QMCSO for any child who otherwise meets the Plan's definition of Dependent. Any benefit payments made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by the child's custodial parent will be made to the child's custodial parent.

ARTICLE III - PLAN OPTIONS AND BENEFITS

SECTION 3.1 FULLY INSURED BENEFIT PROGRAM OPTIONS

3.1.1 Fully Insured Plan Option for Non-Medicare Enrollees

Health Maintenance Organization ("HMO"). HMOs under the Plan are only offered in limited areas. In order for non-emergency services to be covered by an HMO, such services must be received from In-Network Providers. Some HMOs may include prescription drug coverage.

3.1.2 Fully Insured Plan Options for Medicare Enrollees

(a) Medicare Advantage Prescription Drug ("MA-PD") Preferred Provider Organization ("PPO") and MA-PD HMO. MA-PD PPOs and MA-PD HMOs are approved by Medicare, provide all Medicare Parts A and B benefits, and also provide Part D prescription drug benefits. MA-PD PPOs and MA-PD HMOs also may offer additional benefits, services, and programs not provided under Medicare Part A and Part B, such as wellness programs, certain dental benefits, and certain vision benefits.

(1) Auto-Enrollment into Medicare Advantage Prescription Drug Plan with Medicare Part D Prescription Drug Coverage.

At the end of the year in which an Enrollee enrolls in Medicare Parts A and B, and if the Enrollee: (1) does not have Medicare Advantage coverage; (2) does not have Medicare Part D Prescription Drug coverage outside the Plan; and (3) is not Protected, the Plan will inform the Enrollee that it will automatically enroll the Enrollee into a MA-PD benefit program under the Plan for medical and prescription drug coverage.

(i) This automatic enrollment will be effective January 1st of the year following the Enrollee's enrollment in Medicare Parts A and B.

(ii) The Enrollee will be given an opportunity to opt out of this automatic enrollment and stay in the TCN benefit program for medical coverage and Medicare Part D Prescription Drug plan for prescription drug coverage.

(iii) If an Enrollee opts out of this automatic enrollment, the Plan will not automatically enroll the Enrollee again.

(b) Medicare Advantage HMO. Medicare Advantage HMOs are approved by Medicare and provide all Medicare Part A and Part B benefits. Medicare Advantage HMOs also may offer additional benefits, services, and programs not provided under Medicare Part A and Part B, such as wellness programs, certain dental benefits, and certain vision benefits.

SECTION 3.2 BENEFITS OF FULLY INSURED BENEFIT PROGRAMS

The benefits of Fully Insured Benefit Programs (i.e., non-Medicare HMO, HMO with integrated prescription drug coverage, MA-PD PPO, MA-PD HMO and Medicare Advantage HMO benefit programs with integrated prescription drug coverage) are summarized in an insurance contract provided by the Carrier (and also set forth as an Attachment in Exhibit A of this Plan Document), Summary Plan Description, Schedule of Benefits, Health Care Benefit Summary, and Health Care Benefit Highlight Letter(s).

SECTION 3.3 SELF-FUNDED BENEFIT PROGRAM OPTIONS

3.3.1 Self-Funded Plan Options for Non-Medicare Enrollees

ECP Plan. The ECP Plan is available to all non-Medicare-eligible Plan members in all fifty states. The ECP Plan is based on a nationwide network of Providers. It allows services to be performed by both In-Network Providers (generally at a lower cost sharing) and Out-of-Network Providers (generally at a higher cost sharing).

3.3.2 Self-Funded Plan Options for Medicare Enrollees

(a) TCN Plan. The TCN Plan is available to all Plan members enrolled in Medicare. The TCN Plan is based on a nationwide network of Providers. In the TCN Plan, Medicare is the primary payor of claims and TCN is the secondary payor of claims. The TCN Plan allows services to be performed by both Providers participating with Medicare (generally at a lower cost sharing) and Providers who do not participate with Medicare (generally at a higher cost sharing).

(b) Medicare Part D Prescription Drug. Medicare Part D Prescription Drug coverage may or may not be included in the coverage provided by the medical benefit program selected.

(1) When an Enrollee first enrolls in Medicare Parts A or B and if the Enrollee does not have Medicare Part D Prescription Drug coverage outside the Plan, the Plan will inform the Enrollee that it will automatically enroll the Enrollee into the Medicare Part D Prescription Drug benefit program under the Plan.

(i) This automatic enrollment in Medicare Part D Prescription Drug coverage under the Plan will be effective the first day of the second month after the Plan is notified that the Enrollee has enrolled in Medicare Parts A or B.

(ii) The Enrollee will be given an opportunity to opt out of this automatic enrollment. However, if the Enrollee opts out, the Enrollee will not have prescription drug coverage under the Plan.

3.3.3 Self-Funded Plan Options for both Medicare and Non-Medicare Enrollees

(a) Prescription Drug Coverage. Prescription drug coverage may or may not be included in the coverage provided by the medical benefit program selected. If prescription drug coverage is not included in the medical benefit program selected, the Plan will automatically enroll the Primary Enrollee and his or her Dependents in prescription drug coverage.

(b) Dental. The Dental Plan offered by the Plan has two levels of In-Network Providers, with one level of In-Network Providers having lower cost sharing than the other level of In-Network Providers, and also Out-of-Network Providers (generally at a higher cost sharing).

(c) Vision. The Vision Plan offered by the Plan has In-Network Providers (generally at a lower cost sharing) and Out-of-Network Providers (generally at a higher cost sharing).

(d) Hearing. All covered Hearing Plan services must be provided by an In-Network Provider.

(e) Over-the-Counter Benefit. This benefit provides an annual allowance that may be used to purchase eligible over-the-counter drugs and non-prescription healthcare items. This benefit is not available for the non-Medicare HMO plans.

SECTION 3.4 COMPREHENSIVE BENEFIT RULES

3.4.1 General

Benefit rules for this Plan are set forth in this Section of the Plan Document, in the Summary Plan Description, Schedule of Benefits, Health Care Benefit Summary, Health Care Benefit Highlight Letter(s), and/or in the applicable insurance contract provided by the Carrier.

3.4.2 Benefits Payable

Benefits payable under this Plan shall not exceed any benefit maximum, or the lifetime maximums set forth in the applicable Schedule of Benefits or in the applicable insurance contract provided by the Carrier.

3.4.3 Maximum Benefit

(a) The overall annual or lifetime maximum benefit payable under this Plan for all expenses incurred by an Enrollee due to injuries or illnesses is described in the applicable Schedule of Benefits, Health Care Benefit Highlight Letter(s), Health Care Benefit Summary, and the insurance contracts and benefit summaries set forth as Attachments in Exhibit A of this Plan Document. Some covered medical expenses are subject to special, specific maximum annual or lifetime benefits as described in the applicable Schedule of Benefits or the insurance policies or contracts for the insured portion of the Plan.

(b) In addition, an Enrollee may incur a sanction, which is an amount of an otherwise covered or potentially covered expense that the Plan will not pay as a result of a Primary Enrollee's failure to follow Plan provisions (such as the failure to follow Plan provisions for using In-Network Providers).

3.4.4 Women's Health and Cancer Rights Act

(a) Except as may be required under the Fully Insured Benefit Programs, the Plan is voluntarily complying with the Women's Health and Cancer Rights Act. However, if an Enrollee undergoes a mastectomy and if the Plan pays benefits for that surgery, the following services and supplies will also be covered under the Plan:

(1) Reconstruction of the breast on which the mastectomy was performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

(b) Coverage is subject to the same annual deductibles, co-payments, co-insurance rates, and other limitations that apply to other medical procedures that are covered under the Plan.

SECTION 3.5 REFUNDS AND SIMILAR PAYMENTS

Any refund or other similar payment under a Self-Funded Benefit Program or Fully Insured Benefit Program shall be allocated consistent with applicable fiduciary obligations under ERISA.

ARTICLE IV - COORDINATION OF BENEFITS

SECTION 4.1 GENERAL

Coordination of Benefits (COB) is a means of apportioning and prioritizing liability for payment of Claims when more than one health care plan is involved.

This Plan will not pay benefits to or on behalf of an Enrollee if similar or duplicate coverage is available to the Enrollee from, or payable by, other sources (e.g., health plans, comprehensive programs, pre-paid programs, and governmental programs). Such other sources and the Enrollee are liable to this Plan for any sums paid by this Plan for benefits if similar or duplicate benefits are or were available from or payable by the other sources. This Plan has established systems and procedures for coordinating its benefits with benefits from other sources (hereinafter referred to as "COB").

SECTION 4.2 APPLICABILITY

These COB provisions apply to all benefits provided under this Plan, except where precluded by law.

SECTION 4.3 PAYMENT OF BENEFITS

If this Plan is primary, then the provisions of this Plan determine this Plan's liability regardless of any provisions of the other plan.

If this Plan is primary, it may reimburse a secondary plan for any amounts paid which should have been paid by this Plan.

If this Plan is overpaid by the other plan for any claim involving COB, the other plan shall have the right to recover such overpayment. In the event an Enrollee incurs an overpayment, this Plan may recover such overpayment from other benefits for purposes of collecting all or part of the overpayment. The Enrollee's participation in this Plan serves as the participant's deduction authorization.

With regard to any Claim for which this Plan has secondary liability, benefits provided under this Plan shall not exceed the amount of benefits payable if this Plan had been primary.

If the other plan provides benefits in the form of services rather than reimbursement, this Plan may recover the reasonable cash value of services from the other plan in connection with the collection of an overpayment by this Plan.

"Benefits paid or payable" under another plan include the benefits that would have been payable had a Claim been made under the primary plan, or which would have been payable by the primary plan but for the Enrollee's failure to comply with the rules of such plan. Such benefits will not be paid by this Plan when this Plan is the secondary plan.

SECTION 4.4 FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan will have the right to pay over to any organizations making such other payments any amounts it shall determine necessary to satisfy the intent of this provision and amounts so paid will be deemed to be benefits paid under this Plan and, to the extent of such payments, the Trust will be fully discharged from liability under this Plan.

SECTION 4.5 ORDER OF BENEFIT PAYMENT

The plan having the first obligation to pay benefits is termed the "primary plan" and the benefits such plan provides are "primary." The plans or sources that pay benefits after the primary plan are termed the "secondary plan(s)," and the benefits such plans provide are "secondary." The term "other plan" is any other plan or source of payment except this Plan.

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

(b) When the other plan contains a COB provision, the following order of benefit determination applies:

  (1) The plan covering the Enrollee as an employee or non-Medicare retiree is primary over the plan covering the Enrollee as a dependent. If an Enrollee is covered in the same status by more than one plan (e.g., active and active, retiree and retiree, etc.), the plan that covered the Enrollee the longest is primary.

  (2) If the Enrollee is retired or disabled and covered under Medicare and also covered as a dependent of a Spouse who is an active employee, the active employee Spouse's health plan is primary.

  (3) If one plan covers the Enrollee as an active employee and the other covers the Enrollee as a laid-off or retired employee, the plan covering the Enrollee as an active employee is primary.

  (4) If an Enrollee's coverage is provided under a right of continuation provided by federal or state law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee or retiree, or their dependent, is primary and the continuation coverage is secondary.

  (5) When an Enrollee is a dependent child, whose parents are not divorced or separated, the plan covering the Enrollee as a dependent of the parent whose birthday occurs earlier in the calendar year is primary over the plan 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 plan that has covered the dependent child for the longer period of time is primary.

(6) When an Enrollee is a dependent child, whose parents are divorced or separated, and there is a court order or custody agreement establishing financial responsibility with respect to health care expenses of the child, the plan that covers the child as a dependent of the parent with such responsibility is primary. If there is no court decree or State agency order, the order of benefit coordination shall be:

(i) The plan of the parent with physical custody; then (ii) the plan of the stepparent with custody; then (iii) the plan of the parent without custody; then (iv) the plan of the stepparent without custody. If primary determination cannot be made by court order or custody agreement, the birth year rule referred to above will apply.

(ii) If the parents share joint physical and financial responsibility of the dependent child, the plan of the parent whose birthday occurs first in the calendar year is primary. If the two parents' birthdays fall on the same day, the plan that has covered the dependent child for the longer period of time is primary.

(7) If there is a court decree or State agency order (such as a Qualified Medical Child Support Order) that established financial responsibility for medical expenses, the plan covering the parent who has that legal responsibility shall be primary.

(c) When the above sections do not establish an order of benefit determination, the plan that has covered the Enrollee for the longer period of time is primary. This Plan is effective January 1, 2010, and no coverage under any predecessor plan counts toward coverage under this Plan.

(d) If an order of benefit determination cannot be made under the above sections, the allowable expenses shall be shared equally between the two plans.

ARTICLE V - SUBROGATION FOR SELF-FUNDED BENEFIT PROGRAMS

If benefits are paid under the Plan and another party's action or inaction was responsible for the Enrollee or the Enrollee's Dependents having incurred the expenses, the Plan is entitled to be subrogated to all of the Enrollee's, the Enrollee's estate's, or the Enrollee's Dependents' rights to recover damages for such benefits (e.g., automobile accidents that cause medical expenses to be incurred). In that way, financial liability remains where it belongs – with the party responsible for incurring the expenses – while the Plan's costs are reduced. The Plan may require that the Enrollee or the Enrollee's attorney or other representative execute an agreement to hold any sums collected in a plan or escrow account pending agreement with the Plan or its agent, or until distribution is ordered by a court of competent jurisdiction. The Enrollee and the Enrollee's attorneys and representatives may not prejudice the Plan's rights.

In addition, the Plan has a right of reimbursement from any recovery by judgment, settlement, or otherwise, which the Enrollee, the Enrollee's estate, or the Enrollee's Dependents may receive or be entitled to receive from any source, including but not limited to, liability or other insurance covering the third party, uninsured or underinsured motorist insurance, medical payment or personal injury protection insurance, and no-fault insurance and direct recoveries from liable parties.

If the Enrollee or the Enrollee's Dependents are involved in such situation, the Enrollee is required to provide the Plan with whatever assistance is necessary to recover payments made on behalf of the Plan, including providing information regarding the event and cooperating with the Plan. The Plan may require that the Enrollee or the Enrollee's attorney or other representative must execute an agreement to hold any sums collected in a Plan or escrow account pending agreement with the Plan or its agent, or until distribution is ordered by a court of competent jurisdiction. The Enrollee and the Enrollee's attorneys and representatives may not prejudice the Plan's rights.

If the Enrollee or the Enrollee's Dependents receive payment for medical expenses in such a situation, the Enrollee will be required to reimburse the Plan. The Plan shall have a first priority lien on any recovery from a third party. This lien is binding on any attorney, insurance company, or other party who agrees or is obligated to make payment to the Enrollee or the Enrollee's Dependents as compensation for any damages. The lien exists at the time the Plan pays medical benefits. If the Enrollee or the Enrollee's Dependent files a petition for bankruptcy, the Enrollee or the Enrollee's Dependent agrees that the Plan's lien existed in time prior to the creation of the bankruptcy estate.

The Plan's rights to subrogation and reimbursement shall not be reduced by any reason, including but not limited to the made-whole doctrine, the common fund doctrine, acquiescence, duress, estoppel, frustration of purpose, impossibility, impracticability, laches, unclean hands, unconscionability, undue influence, or waiver. The Plan must be repaid in full regardless of whether the settlement or judgment specifically designates the recovery or a portion of it as including medical expenses.

If the Enrollee fails to repay the Plan, the Plan may offset future benefit payments by withholding payments until the entire amount due is reimbursed.

If the Enrollee is enrolled in a Fully Insured Benefit Program, this Article does not apply, and the subrogation and reimbursement rules are provided under the applicable insurance policy or contract, which are included as Attachments in Exhibit A of this Plan Document.

ARTICLE VI - CLAIMS AND APPEALS PROCEDURES

SECTION 6.1 CLAIMS AND APPEALS FOR FULLY INSURED BENEFIT PROGRAMS AND MEDICARE PART D PRESCRIPTION DRUG PLANS

Claims and appeals under Fully Insured Benefit Programs (i.e., claims under the non-Medicare HMO, Medicare Advantage HMO, and MA-PD HMO or PPO) and Medicare Part D Prescription Drug plans are decided by the applicable Carrier. Claims and appeals under the non-Medicare HMO plan are decided in accordance with the Carrier's reasonable procedures, as required by ERISA. Claims and appeals for the Medicare Advantage HMO, MA-PD HMO or PPO, and Medicare Part D Prescription Drug coverage are decided pursuant to the Carrier's reasonable procedures, as required by ERISA, which follow guidance issued by the Centers for Medicare & Medicaid Services (except to the extent superseded by this Plan). To the extent of its responsibility to make determinations on claims for benefits, including the review of Adverse Benefit Determinations, the Carrier has full authority to interpret and apply, in its discretion, the terms of the Plan, including ambiguous terms. The decision of the Carrier is final and binding and will be given full force and effect, unless the interpretation or determination is ruled to be arbitrary and capricious by a court with jurisdiction, overturned by a regulatory body with binding authority, or overturned by another governmental authority. The voluntary appeals process described elsewhere in this Plan Document is not offered for Fully Insured Benefit Programs. Claims and appeals procedures for Fully Insured Benefit Programs are summarized in an insurance contract provided by the Carrier (and also set forth as an Attachment in Exhibit A of this Plan Document).

SECTION 6.2 CLAIMS AND APPEALS FOR MOST SELF-FUNDED BENEFIT PROGRAMS (EXCEPT FOR MEDICARE PART D PRESCRIPTION DRUG PLANS)

6.2.1 How Claims and Appeals are Decided

(a) Claims and appeals under most Self-Funded Benefit Programs (i.e., ECP, TCN, Dental, Vision, Hearing, and non-Medicare Prescription Drug plans), and other special benefit claims will be decided by the Trust, the applicable Carrier, or other delegate, in accordance with its reasonable procedures as required by ERISA. To the extent of its responsibility to make determinations on claims for benefits, including the review of appeals of such Claims determinations or adverse eligibility determinations, the Trust, the applicable Carrier, or other delegate has full authority to interpret and apply, in its discretion, the terms of the Plan, including ambiguous terms. The decision of the Trust, the applicable Carrier, or other delegate is final, binding, and will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

(b) Claims and appeals are decided in a fair and timely manner. The Trust shall take steps to assure that Plan provisions are applied consistently with respect to similarly situated persons.

(c) When reviewing an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or is Experimental and/or Investigational), the Trust, the applicable Carrier, or other delegate shall consult with a health care professional with appropriate training and experience in order to make a decision.

(d) Each claim for benefits under a Self-Funded Benefit Program must be filed in accordance with the procedures set forth in the Summary Plan Description and duly filed no later than the applicable deadline listed in the Summary Plan Description. All claims for benefits will be processed and may be appealed in accordance with the procedures for set forth in the Summary Plan Description.

6.2.2 Authorized Representatives

(a) If the Enrollee has designated an Authorized Representative, the Plan requires a dated, written statement from the Enrollee that he or she has designated another person as his or her Authorized Representative, along with the Authorized Representative's name, address, and telephone number.

(1) However, a health care professional with knowledge of the Enrollee's medical condition may act as an Authorized Representative in connection with an Urgent Care Claim without the Enrollee having to complete a written statement.

(2) If the Plan requires a written statement and the Enrollee is unable to provide one, the Plan requires written proof (e.g., power of attorney for health care purposes, court order of guardian/conservator) that the proposed Authorized Representative has been authorized to act on the Enrollee's behalf.

(3) The Plan reserves the right to withhold information from a person who claims to be an Authorized Representative if there is question about the qualifications of the individual claiming to be the Authorized Representative.

(b) The Plan will honor the designation of an Authorized Representative for up to one year from the date of the written statement, or as otherwise mandated by a court order, before requiring a new written statement.

(c) Once an Authorized Representative has been designated and any required documentation has been provided to the Plan, the Plan will provide information to the Authorized Representative and the Enrollee and, if requested by the Enrollee, route future claims and appeals-related correspondence to the Authorized Representative and not the Enrollee.

(d) The Enrollee may revoke a designation of an Authorized Representative at any time by submitting a signed statement indicating as such to the Plan.

ARTICLE VII - PLAN AMENDMENT OR TERMINATION

SECTION 7.1 PLAN AMENDMENT OR TERMINATION OF THE TRUST

The Plan may be amended, changed, or discontinued at any time by the Committee, subject to the limitations of the Plan Document, applicable settlement agreements, the Trust Agreement, and applicable law and administrative regulations. Absent an express delegation of authority from the Committee, no one has the authority to commit the Trust to any benefit or benefit provision not provided for, or to change the eligibility criteria or any other provisions of the Plan.

Retirees and eligible Dependents do not acquire any vested right to Plan benefits either before or after retirement. The Committee may, and it reserves the right to:

(a) Amend or terminate the Plan or Trust;

(b) Expand, reduce, or cancel coverage for Enrollees;

(c) Change eligibility requirements; and

(d) Otherwise exercise prudent discretion at any time without legal right or recourse by Retirees, Dependents, or any other person.

The Committee may modify or terminate the Trust as permitted by the Trust Agreement and applicable law. If the Trust is terminated, any and all assets remaining after the payment of all obligations and expenses will be used in accordance with the rules set forth in the Trust Agreement.

SECTION 7.2 PAYMENT OF BENEFITS ON PLAN TERMINATION

Retirees and Dependents are not vested in the benefits provided by this Plan. The Committee may terminate this Plan under certain circumstances, in accordance with the applicable terms of the settlement agreement and the Trust Agreement. If the Plan is terminated, benefits for covered services received by an Enrollee before the termination date of the Plan set by the Committee will be paid as long as the Plan’s assets are more than the Plan’s liabilities. Full benefits may not be paid if the Plan’s liabilities are more than its assets.

If there are excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Committee in accordance with the provisions of the Trust Agreement. In no event will assets be paid to or recoverable by any employer, association, or labor organization.

SECTION 7.3 SUMMARY OF PLAN PROVISIONS UPON TERMINATION OF THE TRUST

The Committee is empowered to terminate the Trust, the Plan, and the underlying accounts funding the Plan. The Committee will do so when it determines, in its sole discretion, that the Trust is no longer effectively serving its purposes or that the interests of the Enrollees could be better served through an alternative arrangement. In paying out the assets of the Trust, the Committee is required to recognize this priority of funding: (1) the payment of reasonable and necessary administrative expenses (including taxes); (2) the payment of benefits to Enrollees entitled to payments for Claims arising prior to such termination; and (3) for the benefit of the Enrollees in such fashion as the Committee determines, in accordance with Section 501(c)(9) of the Internal Revenue Code. The Committee will continue distribution until all assets have been liquidated.

SECTION 7.4 PUBLIC HEALTH AND SIMILAR EMERGENCIES

The Committee may determine that a public health emergency or a similar emergency impacting a large number of Enrollees necessitates a temporary change to the benefits described in this Plan Document or in an insurance contract provided by a Carrier (set forth as an Attachment in Exhibit A of this Plan Document). The Committee shall consider relevant declarations of emergency from public authorities, including the U.S. Department of Health and Human Services or corresponding State authorities. If the Committee approves such temporary benefit changes, such changes may conflict with current exclusions in this Plan Document or in an insurance contract provided by a Carrier; such exclusions will become effective again once the emergency has ended or been terminated by the relevant authorities. The Plan will inform the Carriers of any such approved temporary benefit changes.

ARTICLE VIII - USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION 8.1 THE PLAN'S USE AND DISCLOSURE OF PHI

8.1.1 Disclosures Permitted Under HIPAA

The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by the privacy and security regulations under HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment, and health care operations, as those terms are defined under HIPAA.

8.1.2 Disclosures Per Authorization

The Plan will use and disclose PHI as required by law and as permitted by authorization of the Enrollee or Enrollee's Authorized Representative.

8.1.3 Disclosures For Plan Administration

The Plan shall disclose PHI to the Committee for the purpose of plan administration but shall only disclose the minimum necessary information.

SECTION 8.2 THE COMMITTEE'S USE AND DISCLOSURE OF PHI

8.2.1 Committee's Use and Disclosure of PHI

The Committee is the "Plan Sponsor" of the Plan, under HIPAA. With respect to PHI, the Committee agrees to:

(a) Not use or further disclose the information other than as permitted or required by the Plan Document, the Enrollee, or as required by law;

(b) Ensure that any agents to whom the Committee provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Committee with respect to such information;

(c) Not disclose the information for employment-related actions and decisions;

(d) Not use or disclose the information in connection with any other benefit or employee benefit plan offered by the Committee;

(e) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make PHI available to the Enrollee and the Enrollee's Authorized Representative in accordance with the access requirements of HIPAA;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(i) Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA; and

(j) If feasible, return or destroy all PHI received from the Plan that the Committee still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

8.2.2 Access to PHI

Access to PHI may be given only to the Committee and members of the Plan's workforce who receive PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business in carrying out Plan administration functions that the Committee performs for the Plan. The access and use of PHI by the Committee and workforce described above is limited to purposes of the administration functions that the Committee performs for the Plan. The Committee shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

SECTION 8.3 COMPLIANCE WITH THE HIPAA SECURITY RULE

With respect to the HIPAA Security Rule, the Committee will:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation of the Plan's workforce, specific to electronic PHI, is supported by reasonable and appropriate security measures;

(c) Ensure that any agent to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, including, where appropriate, executing Business Associate Agreements; and

(d) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

ARTICLE IX - GENERAL PROVISIONS

SECTION 9.1 GOVERNING LAW

All questions pertaining to the validity and construction of the Trust Agreement, the Plan, and of the acts and transactions of the Committee or of any matter affecting the Plan will be determined under federal law where applicable federal law exists. Where no applicable federal law exists, the laws of the State of Michigan will apply to the Plan, the laws of the State of New York will apply to the Trust, and any other applicable state law will apply to Fully Insured benefit programs.

SECTION 9.2 SEVERABILITY CLAUSE AND CONFORMITY WITH THE LAW

Should any provision of the Plan or this Plan Document or any amendment thereto be deemed or held to be unlawful, or unlawful as to any person or instance, such facts will not adversely affect the other provisions herein and therein contained or the application of those provisions to any other person or instance, unless such illegality will make impossible or impracticable the functioning of the Plan.

To the extent permitted by law, the Committee will not be held liable for any act done or performed in pursuance of any provisions hereof prior to the time that such act or provision is held unlawful by a court of competent jurisdiction.

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

SECTION 9.3 EXAMINATIONS

Generally, the Committee will have the right and opportunity to examine any and all Hospital, medical, or prescription records relating to a Claim under this Plan.

SECTION 9.4 WORKERS' COMPENSATION NOT AFFECTED

This Plan is not issued in lieu of, nor does it affect any requirement for, coverage by any workers' compensation law, occupational disease law, or similar laws.

SECTION 9.5 RELEASE OF INFORMATION

To the extent consistent with applicable state and federal law, an Enrollee making application for benefits will be required by the Plan to authorize any Physician, Hospital, employer, government agency or any other person, corporation or organization having relevant health-related information, which may be required for a proper determination of the Claim by the Plan, to release such information to the Plan. Each Enrollee will also authorize the Plan to release relevant health-related information to third parties, if necessary to provide medical

services, or to facilitate the payment of Claims hereunder; provided, however, no authorization will be required if such authorization would violate applicable state and federal laws. The information will be requested for the purposes of treatment, payment and Plan administration and the authorization is intended to comply with all the requirements of the Administrative Simplification rules of HIPAA. By making a Claim for benefits, an Enrollee will be deemed to have authorized a release of information pursuant to this Article.

Providers shall be authorized to permit the Plan and/or applicable 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 Plan.

A Provider claiming payment from the Carrier must timely furnish a report to the Carrier, in the prescribed form. The Provider must certify upon the report that the Provider is entitled to payment under this Plan 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.

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.

SECTION 9.6 RIGHT TO RECOVERY

Whenever the Committee pays benefits that exceed the amount of benefits that should be paid under the terms of this Plan, the Committee shall have the right, to the greatest extent allowed by law, to recover the wrongfully paid benefits from any person, plan, or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of an Enrollee, the Plan, at its option, may require immediate repayment in full, offset the overpayment from current and future benefit payments or institute legal action to collect the overpayment.

To the extent an overpayment is made, any person, or agent for such person, benefiting from the overpayment will be deemed to hold the excess payment or the benefit received as a result of the excess payment in an equitable and constructive trust for the benefit of the Trust.

SECTION 9.7 LEGAL ACTION BY AN ENROLLEE

No action at law or in equity or otherwise may be brought on any Claim or other matter whatsoever against the Trust, applicable Carrier, or other delegate, unless all of the required Claims and Appeals procedures under Article VI of the Plan have been followed and exhausted.

Any action at law or in equity must be brought within one year from the date of the last decision regarding the Claim or Adverse Benefit Determination rendered by the Trust, Plan, applicable Carrier, or other delegate. However, if a Claim is submitted for voluntary appeal, the one-year time limit is put on hold while the voluntary appeal review process is ongoing. After the voluntary appeal is decided, a new one-year time limit to bring an action at law or in equity will start following the date of the voluntary appeal decision.

This provision will not be deemed to extend or reinstitute any Claim or cause of action that has expired under the time limits set forth in the settlement agreement, this Plan Document and its Attachments, or under any statute if such time limit has already expired.

SECTION 9.8 MISREPRESENTATION OR FALSIFICATION

If any individual knowingly misrepresents or falsifies any information or any matters in connection with a Claim filed for Plan benefits, the Committee may, in its sole discretion, deny all or part of the benefits that might otherwise be due in connection with the Claim. If benefits are paid and it is later determined that they were paid as a result of a misrepresentation or false information then the Committee may, in its sole discretion, withhold future benefits to collect amounts paid in error.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Plan may also obtain reimbursement of interest, professional fees incurred, and other damages related to that overpayment.

If an individual believes that the Plan has terminated his or her coverage in error, that individual can utilize the appeal process set forth in Article VI of the Plan Document.

SECTION 9.9 WORD USAGE

Except as the context may specifically require otherwise, use of the masculine gender shall be understood to include masculine and feminine genders, as well as gender neutral, unless the context requires otherwise. Any reference to the singular may also apply to the plural and vice versa unless the context requires otherwise, or the result would be irreconcilable.

SECTION 9.10 HEADINGS

Headings are for reference and not for interpretation or construction.

SECTION 9.11 CHANGES IN LAWS AND/OR REGULATIONS

Notwithstanding any provisions of the Plan Document and Summary Plan Description to the contrary, the Plan shall modify administration, coverage, and other terms and conditions of the Plan Document and Summary Plan Description, as necessary, to comply with applicable federal laws and regulations.

SECTION 9.12 PAYMENT OF BENEFITS

Benefits are payable to the Retiree whose injury or illness or whose Dependent's injury or illness is the basis for a claim under the Plan, except that:

(a) In the event that an unpaid Hospital bill, Physician's bill, or bill from any other Provider providing medical services or supplies that are covered by this Plan is submitted to the Committee, the applicable Carrier, or other delegate, the payment will be made directly to the Hospital, Physician, or Provider;

(b) No assignment of any present or future right, interest, or benefit under this Plan shall bind the Committee, the applicable Carrier, or other delegate without their written consent thereto;

(c) If any individual is, in the opinion of the Committee, the applicable Carrier, or other delegate, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed for that individual, the Committee the applicable Carrier, or other delegate may, at their option, make such payment to the person or persons who, in the opinion of the Committee, the applicable Carrier, or other delegate, have assumed the care and principal support of such individual. If the individual should die before all amounts due and payable have been paid, the Committee, the applicable Carrier, or other delegate may, at their option, make such payment to the executor, administrator or personal representative of the individual's estate or to the individual's surviving Spouse, parent, child or children, or to any other person or persons who, in the opinion of the Committee, the applicable Carrier, or other delegate, are entitled thereto; and

(d) Any payments made by the Committee, the applicable Carrier, or other delegate in accordance with these provisions shall fully discharge the liability of the Committee, the applicable Carrier, or other delegate to the extent of such payment.

ARTICLE X - PLAN ADMINISTRATION

SECTION 10.1 COMMITTEE AUTHORITY AND INTERPRETATION

The Committee will have the power and authority to increase, decrease, or change benefits, or change eligibility rules, including by adopting Schedules of Benefits, or other provisions of the Plan as may in their discretion be proper or necessary for the sound and efficient administration of the Plan, provided that such changes are not inconsistent with the law or with the provisions of this Plan or with the provisions of the Trust Agreement. The Committee has the discretion to determine eligibility for benefits and to interpret the terms of the Trust and this Plan, including ambiguous terms. The decisions of the Committee as to the granting or denial of benefits and the construing of terms of the Trust and the Plan are reviewed under the "arbitrary and capricious" standard of judicial review by a reviewing court as set forth by the United States Supreme Court in Firestone and Rubber Company, et al. v. Richard Bruch.

SECTION 10.2 ROLE OF CARRIER

For the Plan's Fully Insured Benefit Programs, benefits are provided under an insurance contract between the Committee and the Carrier. Claims for benefits under both Self-Funded Benefit Programs and Fully Insured Benefit Programs are sent to the Carrier. The Carrier, not the Committee, is responsible for deciding and paying Claims under Self-Funded Benefit Programs and Fully Insured Benefit Programs. The Carrier is responsible for determining the amount of any benefits payable under the Plan and providing the Claims procedures to be followed pursuant to the Plan. Except for appeals for eligibility decisions, Over-the-Counter Benefit eligibility decisions, and Over-the-Counter Benefit Claims, which are decided pursuant to the Trust's procedures, appeals are decided pursuant to the Carrier's procedures.

The Carrier also has the authority to require Enrollees enrolled in, or individuals seeking to enroll in, a Self-Funded Benefit Program or Fully Insured Benefit Program to furnish the Carrier with such information as it determines necessary for the proper administration of the Plan.

SECTION 10.3 INFORMATION ABOUT THE TRUST AND THE PLAN

10.3.1 Trust Name

The Trust is known as the UAW Retiree Medical Benefits Trust.

10.3.2 Plan Name

UAW Chrysler Retirees Medical Benefits Plan

10.3.3 The Committee for the UAW Retiree Medical Benefits Trust

The Committee is responsible for the operation of the Trust and the Plan. The Committee consists of six independent members and five members chosen by UAW.

All correspondence to the Committee or any individual member of the Committee should be sent to:

UAW Retiree Medical Benefits Trust

P.O. Box 14309

Detroit, MI 48214

10.3.4 Trustee

The Trustee is State Street Bank.

State Street Bank and Trust Company

200 Newport Ave., JQB7S

North Quincy, MA 02172

10.3.5 Plan Sponsor, Plan Administrator, and Named Fiduciary

The Committee acts as both the Plan Sponsor and the Plan Administrator on behalf of the UAW Chrysler Retirees Employees' Beneficiary Association. The Committee is also the Named Fiduciary for the Plans. The Committee is the ultimate authority on the benefits provided under the Plan. The Committee has delegated administrative responsibility for day-to-day operation of the Plan to its Chief Executive Officer, service providers, Carriers, the Trust, Trust employees, and to Retiree Health Care Connect. Contact information for these entities is:

UAW Retiree Medical Benefits Trust

Plan Administrator

P.O. Box 14309

Detroit, MI 48214

Retiree Health Care Connect

866-637-7555

10.3.6 Employer Identification Number

The Employer Identification Number assigned to the Committee by the Internal Revenue Service is 90-0424876.

10.3.7 Plan Number

The Plan Number for the UAW Chrysler Retirees Medical Benefits Plan is 503.

10.3.8 Agent for Service of Legal Process

Service of legal process may be made upon the Plan Administrator:

UAW Retiree Medical Benefits Trust

Plan Administrator

P.O. Box 14309

Detroit, MI 48214

SECTION 10.4 HOW BENEFITS ARE FUNDED

The benefits provided by the Plan are funded through the Trust. Non-Medicare HMO, MA-PD HMO or PPO, and MA HMO, are Fully Insured Benefit Programs and paid by the applicable Carrier. The remaining plans are Self-Funded Benefit Programs and paid by the Trust.

ARTICLE XI - DEFINITIONS

This section contains definitions of important terms used throughout this Plan Document. When these terms are capitalized in the Plan Document, they have the meanings shown below.

SECTION 11.1 ADVERSE BENEFIT DETERMINATION

A denial, reduction or termination of a benefit, a failure to provide or make payment in whole or in part for a benefit or a denial, or termination of an Enrollee's eligibility to participate in this Plan;

A benefit reduction resulting from the application of any Hospital pre-admission review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary; or

The Plan's payment of less than the total amount of expenses submitted with regard to a Claim, even when the Plan is paying the portion of the Claim that is covered under the terms of the Plan (e.g., the Plan pays less than 100% due to an Enrollee who has not yet satisfied the out-of-pocket maximum).

SECTION 11.2 ATTACHMENT(S)

The documents identified in Exhibit A and attached to this Plan Document which, together with this Plan Document and other relevant documents, constitute the written plan under ERISA.

SECTION 11.3 AUTHORIZED REPRESENTATIVE

A person who can act on an Enrollee's behalf to file a Claim or appeal an Adverse Benefit Determination under the Plan. The following individuals may be recognized as an Authorized Representative:

(a) Provider who is treating the Enrollee and who prescribes the treatment or service which is the subject of a Claim;

(b) Spouse;

(c) Dependent Child aged 18 or older;

(d) Parents or adult siblings;

(e) Court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator;

(f) Union benefit representative; or

(g) Other adult.

SECTION 11.4 CARRIER

An entity that pays benefits and/or administers a benefit program under the Plan, including, but not limited to, a BlueCross BlueShield organization, a commercial insurance company, a Health Maintenance Organization, a Medicare Advantage Organization, a Medicare Advantage Prescription Drug plan, a pharmacy benefit manager, or an administrative services provider.

SECTION 11.5 CLAIM

A request for a Plan benefit, medical or otherwise, or an eligibility determination made by an Enrollee or the Enrollee's Authorized Representative, in accordance with the Plan's Claims procedures.

SECTION 11.6 CLAIMANT

An Enrollee or Enrollee's Authorized Representative who submits a Claim or appeal.

SECTION 11.7 COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law that gives certain eligible participants the right to continue health care coverage at group rates for a set period of time.

SECTION 11.8 COMMITTEE

The Committee for the UAW Retiree Medical Benefits Trust. The Committee was formed by operation of the court-approved settlement agreement between Chrysler Group LLC and the UAW. The Committee acts on behalf of the Employees' Beneficiary Association ("EBA") for Chrysler Group LLC with regard to retiree medical and prescription drug coverage. The EBA, through the Committee, has established and maintains the Plan.

SECTION 11.9 DAY(S)

Unless otherwise specified in the Plan, a reference to "day(s)" means calendar days.

SECTION 11.10 DEPENDENT(S)

The Primary Enrollee's eligible Spouse, same-sex domestic partner, and/or Dependent Children.

SECTION 11.11 DEPENDENT CHILD (DEPENDENT CHILDREN)

Generally, a child for whom the Primary Enrollee can legally claim an exemption on his or her federal income tax return. To be eligible for coverage under the Plan, the child must meet the Plan's eligibility requirements for Dependent Children.

SECTION 11.12 ECP OR ENHANCED CARE PREFERRED PROVIDER ORGANIZATION

A Self-Funded Benefit Program offered under the Plan to Enrollees who are not eligible for Medicare.

SECTION 11.13 ENROLLEE

Each Retiree or other Primary Enrollee and each of his or her eligible Dependents, if any, enrolled in coverage under the Plan.

SECTION 11.14 ERISA

The Employee Retirement Income Security Act of 1974, as amended from time to time.

SECTION 11.15 EXPERIMENTAL AND/OR INVESTIGATIONAL

A service, supply, device, or drug that meets any of the following conditions, as determined by the applicable Carrier:

(a) Is described as an alternative to more conventional therapies in the protocols or informed consent document of the Provider that performs the service or prescribes the supply;

(b) May be given only with the approval of an Institutional Review Board as defined by federal and state law;

(c) There is an absence of authoritative medical or scientific literature on the subject;

(d) A significant amount of authoritative medical or scientific literature published in the United States shows that medical or scientific experts classify the service, supply, device, or drug as experimental or investigational or indicates that more research is required;

(e) The FDA has not granted approval of the service, supply, device, or drug (if such FDA approval is required);

(f) Exceeds an FDA-approved limit; or

(g) Available only through participation in clinical trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

Notwithstanding the above, if a service, supply, device or drug is approved by the FDA, then the Carrier cannot classify the service, supply, device or drug as Experimental and/or Investigational.

SECTION 11.16 FDA

The Food and Drug Administration.

SECTION 11.17 FULLY INSURED BENEFIT PROGRAMS

The following benefit program options are Fully Insured Benefit Programs: non-Medicare HMO, MA-PD HMO and PPO, and Medicare Advantage HMO plans. The Trust has entered into group insurance contracts with Carriers to provide benefits through some Fully Insured Benefit Programs. Summaries of the benefits offered by the Fully Insured Benefit Programs are set forth in the insurance contract provided by the Carrier, which are included as Attachments in Exhibit A of this Plan Document.

SECTION 11.18 HEALTH CARE BENEFIT HIGHLIGHT LETTER(S)

A letter issued at least annually by the Trust outlining benefit changes and enhancements.

SECTION 11.19 HEALTH CARE BENEFIT SUMMARY

A letter issued by the Trust to new Enrollees summarizing updates to the Health Care Benefit Highlight Letter(s) and Schedule of Benefits since the previous Summary Plan Description was released.

SECTION 11.20 HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended from time to time. Except to the extent required for Fully Insured Benefit Programs, the Plan is exempt from certain of HIPAA's portability and nondiscrimination requirements under ERISA § 732(a) because the Plan has no participants who are current employees. The Plan is subject to HIPAA's privacy and security requirements.

SECTION 11.21 HMO OR HEALTH MAINTENANCE ORGANIZATION

A benefit program with a network of In-Network Providers that have agreed to treat Enrollees for a specified payment amount. An HMO usually covers only Plan benefits received from In-Network Providers, except in cases of emergency or urgent care.

SECTION 11.22 HOSPITAL

A facility that 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 Providers. A Hospital continuously provides 24-hour a day nursing service by registered nurses. A rehabilitation institution is considered to be a Hospital if the institution is approved as such under this Plan by the applicable Carrier. 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. An In-Network Hospital may be referred to as a "Participating Hospital".

SECTION 11.23 INFORMAL ENROLLEE COMMUNICATIONS

All Plan communications sent to Enrollees, with the exception of the Attachments, Health Care Benefit Highlight Letter(s), and the Summary Plan Description.

SECTION 11.24 IN-NETWORK PROVIDERS

Providers that participate in TCN, ECP, or other networks providing Plan benefits, such as HMOs, MA-PD PPOs and HMOs, and MA HMOs. In-Network Providers are also referred to as "participating Providers" or "network Providers".

SECTION 11.25 MEDICALLY NECESSARY (MEDICAL NECESSITY)

A service, supply, device, or drug that is all of the following (as determined by the applicable Carrier):

(a) Provided by or under the direction of a Provider who is authorized to provide or prescribe it;

(b) Necessary in terms of generally accepted American medical standards;

(c) Consistent with the symptoms or diagnosis and treatment of an illness or injury;

(d) Not provided solely for the Enrollee or Provider's convenience;

(e) Appropriate given the Enrollee's circumstances and condition;

(f) A "cost-efficient" supply or level of service, device, or drug that can be safely provided to the Enrollee;

(g) Safe and effective for the illness or injury for which it is used; and

(h) Not considered Experimental and/or Investigational.

SECTION 11.26 MEDICARE

A federal health care program for individuals aged sixty-five (65) or older, and for certain individuals under age sixty-five (65) who have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). Medicare also refers to the services and supplies that Enrollees are eligible to receive under

Medicare Part A (inpatient hospital services, care in a skilled nursing facility, hospice care, and some home health care), Part B (Physician visits, outpatient care, DME, and preventive services), Part C (known as Medicare Advantage and covers all Medicare Parts A and B benefits), and/or Medicare Part D (prescription drug coverage).

SECTION 11.27 MEDICARE ADVANTAGE OR MA PLAN

A Medicare health plan approved by the Centers for Medicare & Medicaid Services and administered by a private insurance company. A Medicare Advantage Plan requires enrollment in Parts A and B of Medicare and covers all the same benefits as Medicare Parts A and B, and sometimes includes additional benefits.

SECTION 11.28 MEDICARE ADVANTAGE PRESCRIPTION DRUG OR MA-PD PLAN

A Medicare health plan approved by the Centers for Medicare & Medicaid Services and administered by a private insurance company. A Medicare Advantage Prescription Drug Plan requires enrollment in Parts A and B of Medicare and covers all the same benefits as Medicare Parts A and B, Medicare Part D (prescription drug) benefits, and sometimes includes additional benefits.

SECTION 11.29 OUT-OF-NETWORK PROVIDERS

Providers that do not participate in the TCN, ECP, or other networks providing Plan coverage, such as HMOs, MA plans and MA-PD plans. When the Enrollee uses an Out-of-Network Provider, the Enrollee generally is responsible for paying the applicable out-of-network deductible and co-insurance, as well as any amounts in excess of the Allowed Amount. Out-of-Network Providers may also be referred to as “non-network Providers”.

SECTION 11.30 PHI OR PROTECTED HEALTH INFORMATION

Defined by HIPAA as information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form of medium that is created or received by a health plan, health care provider, or health care clearinghouse. In order to be PHI, the information must relate 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.

SECTION 11.31 PHYSICIAN

A Doctor of Medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform surgery at the time and place services are

rendered or performed. As used herein, Physician also includes 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:

(a) "Dentist" means a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) who diagnoses, prevents, and treats diseases of the teeth and related structures. A dentist also may prescribe medications.

(b) "Podiatrist" means a Doctor of Podiatric Medicine (D.P.M.) or a Doctor of Surgical Chiropody (D.S.C.) who diagnoses, prevents, and treats ailments of the feet. A podiatrist also may prescribe medications.

(c) "Chiropractor" means a Doctor of Chiropractic (D.C.) who diagnoses and treats subluxations or misalignments of the spinal column and related bones and tissues which produce nerve interference. Under the Plan, a chiropractor may not prescribe medications, perform invasive procedures or incisive surgical procedures, provide outpatient physical therapy services, or perform physical examinations not related to the spine and related to bones and tissues.

SECTION 11.32 PLAN

The UAW Chrysler Retirees Medical Benefits Plan.

SECTION 11.33 PLAN YEAR

The Plan Year begins on January 1 and ends on December 31.

SECTION 11.34 PPO OR PREFERRED PROVIDER ORGANIZATION

A benefit program with a network of In-Network Providers that have agreed to treat Enrollees for a specified payment amount. Covers all Medically Necessary Plan benefits whether they are received from In-Network or Out-of-Network Providers. Enrollee cost sharing will generally be higher if Plan benefits are received from Out-of-Network Providers.

SECTION 11.35 PRIMARY ENROLLEE

The person who is enrolled in the Plan and whose Dependents may be eligible for coverage because of the person's enrollment. The Primary Enrollee may be a Retiree, a surviving Spouse, or a surviving same-sex domestic partner.

SECTION 11.36 PROTECTED

Primary Enrollees fit within one of two categories: "Protected" or "General". These categories relate to certain differences in cost sharing and contributions. If a Primary Enrollee is "Protected" so are their Dependents. A Primary Enrollee and his or her Dependent(s) fit

within the “General” category when the Primary Enrollee does not meet any of the following tests to be considered “Protected”:

(a) Is a Retiree who retired prior to October 1, 1990;

(b) Is a surviving Spouse or surviving same-sex domestic partner, whose Retiree spouse retired prior to October 1, 1999; or

(c) Is a Retiree who receives both: (1) an annual pension benefit income of $8,000 or less; and (2) a monthly pension benefit rate of $33.33 or less per month per year of credited service.

SECTION 11.37 PROVIDER

A person (such as a Physician) or a facility (such as a Hospital) that provides health care services.

SECTION 11.38 RETIREE

A former employee who is eligible for benefits under the Plan according to the standards set forth in the Eligibility Section of this Plan Document.

SECTION 11.39 RETIREE HEALTH CARE CONNECT

The service provider hired by the Trust to administer the Plan’s eligibility rules and provide service and support to Enrollees through an online portal and call center. Formerly known as the Eligibility Benefits Center.

SECTION 11.40 SCHEDULE OF BENEFITS

A document containing detailed information regarding covered benefits and Enrollee cost sharing, including copayments, coinsurance, and deductibles for the different Self-Funded Benefit Programs and Fully Insured Benefit Programs offered under the Plan. The Schedule of Benefits is adopted from time to time by the Committee or its delegate as an addendum to the most current Summary Plan Description and provided to Primary Enrollees.

SECTION 11.41 SELF-FUNDED BENEFIT PROGRAMS

The following benefit program options are Self-Funded Benefit Programs: ECP, TCN, non-Medicare Prescription Drug, Medicare Part D Prescription Drug, Dental, Vision, Hearing, and Over-the-Counter Benefit plans. The Trust provides benefits through some Self-Funded Benefit Programs. Summaries of the benefits offered by the Self-Funded Benefit Programs are set forth in this Plan Document, the Schedule of Benefits, and the Summary Plan Description.

SECTION 11.42 SPOUSE

A same-sex or opposite-sex individual who is recognized as married to a Retiree under IRS rules. This includes an individual in a common-law marriage with a Retiree if the relationship is recognized under IRS rules.

SECTION 11.43 SUMMARY PLAN DESCRIPTION

A document required by ERISA that contains an overview of the Self-Funded Benefit Programs and Fully Insured Benefit Programs offered under the Plan and detailed information regarding covered benefits. The Summary Plan Description is provided to Primary Enrollees.

SECTION 11.44 TCN OR TRADITIONAL CARE NETWORK

A Self-Funded Benefit Program offered under the Plan to Enrollees who are enrolled in Medicare.

SECTION 11.45 TRUST

The UAW Retiree Medical Benefits Trust, as operated by the Committee pursuant to the terms of the court-approved settlement agreements between the UAW and Chrysler Group LLC, Ford Motor Company, and General Motors Company, and as thereafter amended by the Committee. The Trust also may be referred to as a VEBA.

SECTION 11.46 UAW

The International Union, United Automobile, Aerospace and Agricultural Implement Workers of America.

SECTION 11.47 UNITED STATES OR U.S.

Encompasses all territories that have applied and been granted statehood to be a part of the U.S. and all territories that have been determined by the U.S. State Department to be property of the U.S., including the District of Colombia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and any other territory so determined.

SECTION 11.48 URGENT CARE

Care needed for a sudden illness or injury that needs medical care right away but is not life threatening.

SECTION 11.49 VEBA

A Voluntary Employees' Beneficiary Association, which is a tax-exempt employee welfare benefit fund that is held in trust for the benefit of covered participants.

EXHIBIT A: INSURANCE CONTRACTS AND OTHER BENEFIT SUMMARIES

Blue Care Network (BCN) HMO

Blue Care Network (BCN) Advantage MA HMO

Blue Cross Blue Shield (BCBS) MA-PD

Health Alliance Plan (HAP) HMO

Health Alliance Plan (HAP) MA HMO

Humana HMO

Humana MA HMO

Kaiser Permanente HMO

Kaiser Permanente MA HMO

Optum Rx Part D Plan (PDP)

United Healthcare (UHC) MA-PD