

Schedule of Benefits for UAW-Ford Retirees

Addendum to the Summary Plan Description
Published: January 2010

The Committee of the UAW Retiree Medical Benefits Trust is pleased to provide you with this Schedule of Benefits as a supplement to your Summary Plan Description booklet. This Schedule of Benefits contains information about the preventive services that are covered under your medical plan and cost-sharing obligations applicable to your health care benefits effective January 1, 2010. You should refer to this Schedule of Benefits along with your Summary Plan Description.

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This Schedule of Benefits is incorporated into and made part of the UAW Retiree Medical Benefits Trust Summary Plan Description. If you have questions that are not answered in these materials, contact Retiree Health Care Connect (877-829-9444) or your health care Carrier.

Cost-Sharing Items for 2010

The following table outlines the major provisions of the Medical Plans offered by the UAW Retiree Medical Benefits Trust effective January 1, 2010. The amounts may be adjusted annually or at other times as determined by the Committee.

Note: Some plan benefits will be different depending on whether you are a General or Protected Retiree or Surviving Spouse. A Protected Retiree or Surviving Spouse is one who is receiving an annual pension benefit income of \$8,000 or less **and** a monthly pension benefit rate of \$33.33 or less per month per year of credited service. A General Retiree or Surviving Spouse is one who is receiving an annual pension benefit income of more than \$8,000 **or** a monthly pension benefit rate over \$33.33 per month per year of credited service. Most Retirees and Surviving Spouses will be General Retirees. If you have any question about your status, contact Retiree Health Care Connect (877-829-9444).

Cost-Sharing Items		Protected Retiree	General Retiree
Monthly Contribution for All Plans	Single	\$0	\$15
	Family	\$0	\$30
Deductible for PPO & TCN	In-Network		
	Single	\$0	\$170
	Family	\$0	\$340
	Out-of-Network		
	Single	\$0	\$170
	Family	\$0	\$340
Co-Insurance	In-Network	0%	10%
	Out-of-Network	10%	30%
Maximum Out-of-Pocket Expenses for PPO & TCN	In-Network		
	Single	\$0	\$285
	Family	\$0	\$570
	Out-of-Network		
	Single	\$0	\$570
	Family	\$0	\$1,140
Office Visit Co-payment	100% Traditional Care Network (TCN)		
	50% PPO		
	\$10 HMO		
Emergency Room Co-payment	PPO, TCN & HMO (waived if admitted)	\$0	\$100
	Medicare Advantage	\$0	\$50
Retail Prescription Drug Co-payment	Generic	\$10	
	Brand	\$25	
Mail Order Prescription Drug Co-payment	Generic	\$20	
	Brand	\$50	

Preventive Care Services/Screenings

The specific limitations may be adjusted from time to time and are in accordance with guidelines set by accepted national standards. The current coverage is reflected in the following table.

Service	Application and Limitations
PAP Smear	1 per year
Proctoscopic Exams Without Biopsy	1 every 3 years, for participants age 40 and older
Mammogram	1 per year, for participants age 40 and older
Prostate-Specific Antigen (PSA)	1 per year, for participants age 40 and older
Fecal Occult Blood or Fecal Immunochemical Test	1 per year, for participants age 50 and older
Flexible Sigmoidoscopy, Barium Enema, Colonoscopy	For participants age 50 or older: 1 Flexible Sigmoidoscopy or 1 Barium Enema every 5 years OR 1 Colonoscopy every 10 years
Total Serum Cholesterol with LDL Test	1 every 5 years, for participants age 20 and older
Hepatitis C Screening	For participants at risk, or who have signs or symptoms that may indicate a Hepatitis C infection
Well Baby Care	6 visits to physician during first 2 years of life
Immunizations and Vaccinations	Coverage is based on the recommendations and approvals of the Advisory Committee on Immunization Practices, including appropriate dosages, ages and frequency of administration (consult your Carrier for current provisions)
Cancer Antigen 125 (CA-125) Screening	Covered

Medicare Part B Premium Benefit

A Medicare Part B Premium Benefit is provided to help you pay for Medicare Part B coverage. You will receive this benefit if you are a Retiree or Surviving Spouse eligible to receive a benefit under the UAW-Ford Retirement Plan (other than a benefit payable as a result of a deferred vested benefit or a pre-retirement survivor benefit). The Medicare Part B premium benefit for 2010 is \$76.20 per month.

Retirees and Surviving Spouses eligible for Medicare Part B must enroll and maintain continued enrollment in Medicare Part B to be eligible to receive this Benefit. Retirees under age 65 who are disabled or have End State Renal Disease are also eligible to receive the Benefit, provided they are enrolled in Medicare Part B. If you are eligible, the Medicare Part B Premium Benefit will be included in your pension check.

Hearing Aid Coverage

AudioNet America Hearing Aid Program benefits will be payable as listed below:

Service	Participating Provider 1	How often you can utilize the service	What does this mean to you
Audiometric Examination	Covered In Full	Once every 36 months	Audiometric examinations tests must be performed by a physician or audiologist.
Hearing Aid Evaluation Test (including Conformity Evaluation)	Covered In Full	Once every 36 months per ear	Hearing aid evaluation tests must be performed by a physician or audiologist. Conformity Evaluation means, after a hearing aid is prescribed and fitted, one visit to the prescribing physician or audiologist by the covered person subsequent to obtaining the hearing aid for an evaluation of its performance and a determination of its conformity to the prescription.

Digital Hearing Aids (including acquisition costs and dispensing fees)	Mid-level standard digital hearing aids will be covered in full. (See Exhibit I)	Once every 36 months per ear	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 the following, if necessary: 1) a single hearing aid unit or binaural hearing aids if the person qualifies; 2) ear mold, necessary cords, tubing and connectors; 3) standard package of batteries; 4) earphone (often referred to as a receiver) or oscillator; and 5) two-year repair warranty and one year loss and damage warranty.
Replacement Ear Molds (for children up to age seven)	Covered In Full	No more than 4 replacement ear molds annually for children up to age 3. No more than 2 replacement ear molds annually for children ages 3 – 7.	Children up to age 3 will be eligible for no more than 4 replacement ear molds annually. Children ages 3 – 7 are eligible for no more than 2 replacement ear molds annually.

For any upgrades in service(s), the eligible enrollee will receive the discounted price negotiated with the participating provider.

“Participating Provider” means a physician, audiologist or dealer that participates in the AudioNet America Hearing Aid Program administered by SVS, Inc. as defined here:

For the initial hearing aid payable under this Plan, or for each occurrence for a person up to age 18, a medical examination of the ear must first be performed by a physician before the hearing aid, payable by this coverage, will be covered. The physician’s examination is not a covered benefit under this program.

Coverage includes 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.

Coverage includes hearing aids of the following functional design: in-the-ear, behind-the-ear (including air conduction and bone conduction types), in-the-canal, completely-in-the-canal and on-the-body, but only if 1) the hearing aid is prescribed based upon the most recent audiometric

examination and most recent hearing aid evaluation test: and 2) the hearing aid provided by the dealer is the make and model prescribed by the physician or audiologist and is certified as such by the physician or audiologist.

In order for the charges for services and supplies described above to be payable as a hearing aid expense benefit, upon each occasion that a covered person receives such services and supplies the covered person must have an audiometric examination and obtain a medical examination of the ear by a physician (for an initial hearing aid or for each hearing aid if the person is under age 18), and such medical examination and audiometric examination must result in a determination that a hearing aid would compensate for the loss of hearing acuity. Charges for audiometric examinations, hearing aid evaluation tests or hearing aids will not be paid if the date of service is beyond six (6) months of the most recent medical examination of the ear. A prescription from the participating physician or audiologist is required when a hearing aid is purchased.

An audiogram is a covered service when done to measure the extent of hearing loss in terms of deciding the appropriateness of a hearing aid. In the case of audiometric tests performed in the evaluation of a medical or surgical condition in which the recommendation of a hearing aid would be inappropriate and not intended, such tests are not covered.

Hearing aid coverage will pay the dealer's cost for the hearing aid, including binaural hearing aids for those eligible, plus fees for dispensing the hearing aid, including ear mold and follow-up visits within six (6) months of fitting if the hearing aid is prescribed in conjunction with the most recent audiometric exam and hearing aid evaluation test and is the make and model prescribed by the physician or audiologist. Applicable benefits will be covered in full only when obtained from a participating provider.

Out-of-Network Benefits:

Should an eligible enrollee live within 25 miles of a Network provider, a Network provider must be utilized in order to receive the outlined "covered in full" benefits. If an eligible enrollee living within 25 miles of a Network provider chooses to receive hearing aid services and materials from a Non-Network provider, there is no out-of-network coverage. Should an eligible enrollee live more than 25 miles from a Network provider, and choose to receive hearing aid services and materials from a Non-Network provider, they will be reimbursed at the In-Network Discounted Provider Fee Schedule level.

Dental Coverage

How Dental Coverage Works

The UAW Retiree Medical Benefits Trust (Trust) provides dental coverage to you and your eligible dependents. A Dental Benefits Manager, Delta Dental of Michigan, whose contact information is listed in your Schedule of Benefits, administers this coverage for most retirees. (Midwestern Dental DHMO is available in Michigan, and plan provisions can be obtained directly from the plan.) The specific provisions of the dental coverage, the range of covered

services, eligibility rules and so forth may change from time to time as determined by the Trust. If you have questions as to whether or not a particular dental service or expense is covered, you should contact the Dental Benefits Manager or have your Dentist submit a treatment plan for expenses of \$200 or more before receiving treatment to insure that you will not incur unexpected expenses for dental treatment.

Under the Traditional Delta Dental PPO Point-of-Service Plan (PPO POS), dental services for you and your eligible dependents are paid at the benefit level outlined under the Dental Benefits At-A-Glance. You do not have to satisfy a dental Deductible before the Plan covers the services. Dental benefits are paid up to a maximum of \$1,700 per person per calendar year.

Orthodontia services are covered for all Plan participants who are under age 19. Most orthodontic services are covered at 50%, subject to a lifetime maximum of \$2,000.

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 are not counted against the annual benefit limit or the lifetime orthodontic limit. Instead, the regular Co-payments under medical coverage provided by the Trust will be required for all such services. Similarly, dental services provided in a hospital generally are not covered as dental benefits, but may be covered as medical expenses if they qualify for such coverage.

Dental Benefits At-A-Glance

	PPO Dentist	Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays
Class I Benefits			
Diagnostic and Preventive Services – includes exams, cleanings, fluoride and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Class II Benefits			
Radiographs – X-rays	100%	90%	90%
Minor Restorative Services – includes fillings	100%	90%	90%
Periodontic Services – to treat gum disease	100%	90%	90%
Endodontic Services – includes root canals	100%	90%	90%
Relines and Repairs – to bridges and dentures	100%	90%	90%
Other Basic Services – misc. services	100%	90%	90%
Extractions – removal of teeth	100%	90%	90%
Oral Surgery – extractions and other dental surgery other than extractions	90%	90%	90%
Major Restorative Services – includes crowns	90%	90%	90%

	PPO Dentist	Premier Dentist	Nonparticipating Dentist
	<i>Plan Pays</i>	<i>Plan Pays</i>	<i>Plan Pays</i>
Class III Benefits			
Prosthodontic Services – includes bridges and dentures	70%	50%	50%
Class IV Benefits			
Orthodontic Services – includes braces (treatment must begin prior to age 19 and coverage will continue to the end of treatment or until the maximum has been reached)	60%	50%	50%

Dental Covered Charges

Your Delta Dental Plan benefits cover Dentist’s charges that you are required to pay for necessary dental services and supplies, up to the Allowed Amount for such services.

If you have a dental problem that can be treated in more than one way, the procedure that provides a cost-effective, professionally satisfactory result is covered.

The following is a list of services by Class:

Class I Services

- Routine oral exams, cleaning and scaling, but not more than twice for each covered person during any calendar year;
- Three cleanings per calendar year if you have a documented history of periodontal disease; a fourth cleaning is allowed during the two calendar years following periodontic surgery;
- Topical application of fluoride, generally limited to two applications per year for patients under age 20;
- Space maintainers to replace prematurely lost teeth for dependent children under age 19 payable one per area per lifetime (coverage will terminate at the end of the day immediately preceding the dependent child’s 19th birthday);
- Emergency treatment to relieve dental pain; and
- Brush biopsy one per calendar year, subject to Plan standards.

Class II Services

- Dental X-rays, including full mouth X-rays once during each period of five consecutive calendar years, supplementary bitewing X-rays once in any calendar year and dental X-rays that are required for the diagnosis of a specific treatment;
- Extractions, including those needed for orthodontic treatment;
- Oral surgery;
- Fillings made of amalgam, silicate, acrylic, synthetic porcelain and composites on front teeth only, as appropriate, to restore diseased or accidentally injured teeth;

- General anesthetics and intravenous sedation when necessary and used with oral or dental surgery;
- Periodontics and treatment of other gum or mouth tissue diseases including periodontal maintenance cleanings;
- Endodontics, including root canal therapy;
- Injection of antibiotics by the attending Dentist;
- Occlusal guard once in a lifetime;
- Repair or recementing of crowns, inlays, onlays, bridgework and dentures; or relining or rebasing dentures more than six months after installation, but not more than once in any period of 36 consecutive months;
- Inlays, onlays, gold fillings or crown restorations but only when a tooth, as a result of extensive caries or fractures, cannot be restored with the filling materials described above;
- Replacement of crowns more than three (3) years after installation of an initial or replacement crown if the crown has been damaged and cannot be made serviceable, or if there is recurrent decay under the existing crown or decay at a crown-to-natural-tooth margin that cannot be repaired by a direct-fill restoration;

Class III Services

- Initial installation of fixed bridgework, including inlays and crowns as abutments;
- Initial installation of partial or full removable dentures, including any attachments and adjustments during the six months after installation;
- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or bridgework, or the addition of teeth to an existing partial removable denture or to bridgework if:
 - The replacement or addition of teeth is necessary to replace teeth extracted after the existing denture or bridgework was installed;
 - The existing denture or bridgework cannot be made serviceable and at least five years have passed since its installation; and
 - The existing denture is an immediate temporary denture and replacement of a permanent denture occurs within 12 months of the first installation of the immediate temporary denture.
- Cosmetic bonding of eight front teeth for children age eight through the end of the calendar year in which they become age 19 if required because of severe staining, but not more frequently than once in any period of three consecutive years.

Class IV Services

- Orthodontia (teeth straightening), as follows:
 - Continuous treatment must begin before the patient reaches age 19;
 - Benefits are subject to a \$2,000 lifetime maximum per eligible person; and
 - Services include preventive and corrective treatment of dental irregularities resulting from injury or the abnormal growth and development of teeth.

Under the Delta Dental PPO POS plan you are free to visit any licensed dentist anywhere, but you will save the most money by visiting one of the 68,000 dentists throughout the United States who participate in Delta Dental PPO. If you go to a non-PPO dentist, you also have access to more than 128,000 dentists nationwide who participate in Delta Dental Premier.

When dentists sign contracts to participate with Delta Dental, they agree to accept Delta Dental's fee determination as payment in full for covered services. This guaranteed acceptance reduces your copayments and deductibles and eliminates balance billing.

In addition, all dentists who participate with Delta Dental PPO and Delta Dental Premier agree to submit claims on behalf of their patients, making the network easy-to-use and hassle-free.

Contact Delta Dental of Michigan at 800-524-0149, or go to Delta Dental's website at www.deltadentalmi.com to find network Dentists, or for additional information about nominating new network Dentists.

Dental Expense Limitations and Exclusions

Under the Delta Dental Plan, certain dental services have limitations or exclusions. You will be notified of these limitations and exclusions when your treatment plan is considered or at the time you receive the services. If you have any questions about dental limitations and exclusions, please contact the Dental Benefits Manager listed in your Schedule of Benefits. You can find the list of limitations and exclusions at www.deltadentalmi.com, or by calling Delta Dental at 800-524-0149.

Alternative Dental Plans

If you live in an area served by an alternative dental plan that is approved by the Trust, you may elect Dental coverage under that plan in place of the Traditional Plan's coverage.

With the Rolling Enrollment system, there is not a specific enrollment period. You may change your dental plan election during any month of the year (provided 12 months have elapsed since your last change).

To find out if an alternative dental plan is offered in your area, you can call Retiree Health Care Connect at 877-829-9444.

If you are enrolled in an alternative dental plan and need more information regarding what is covered under that plan, you should call the alternative dental plan directly.

Vision Coverage

Coverage Under the Vision Program

If you are enrolled in the Traditional Care Network (TCN) plan, a PPO or an HMO (except for Health Alliance Plan (HAP) of Southeastern Michigan), this section describes your Vision Care Program. The Vision Program is administered by SVS. However, if you are enrolled in HAP, your Vision Care coverage will be provided by that plan, and you should contact the carrier for information about vision benefits.

How Vision Coverage Works

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

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

- One vision examination (by an optometrist or an ophthalmologist) in any period of 12 months plus one referral (when medically necessary) to an ophthalmologist for re-examination within 60 days from the date of initial examination. (For those residing within 25 miles of a network provider, referral must be made by the Network provider.)
- One pair of lenses and frames or contact lenses in any period of 24 months.
- Contact lenses in lieu of regular lenses and frames.
- Children, to the end of the calendar year in which they become 16 years of age, who are diagnosed as having severe progressive myopia (i.e., myopia at 2.00 diopter or greater and progressing at the rate of 1.00 diopter or more per year in the meridian of greatest change) will be eligible for an additional 12 months (365 days) after the most recent examination paid for by the program.

If the examination reveals a change of 1.00 diopter or more has occurred during the preceding 12 months, appropriate corrective lenses (but not frames) will be provided by the program. If the change is less than 1.00 diopter, lenses will not be provided by the program until 24 months has elapsed since the program provided the most recent lenses. Subsequent examinations will be limited to the normal 24-month interval unless the child is again diagnosed as having severe progressive myopia.

- If you (or your eligible dependent) are an insulin-dependent diabetic, you may obtain a vision examination each calendar year. If you have a change of .5 diopter or 10 degree axis, you may receive one pair of lenses on an annual basis at the new prescription (but not new frames).
- When eligible for lenses, and until the enrollee's 13th birthday, coverage will be provided for scratch-guard coating on plastic lenses when received from a network provider. Scratch-guard coating will be covered under the program not more frequently than once every two calendar years.
- Warranty on lenses and/or frames received from a Network provider.

Most lenses or frames you receive from a network provider are under warranty for two years (there is a one-year warranty for rimless frames). The warranty begins on the date you receive your lenses and/or frames and works according to a point system.

During the two-year warranty period (or one-year period for rimless frames), a total of 10 replacement points are provided for services received. If any eyeglass part is repaired or replaced, the point value of the repaired or replaced part, as described below, will be subtracted from the total number of replacement points remaining. Each lens = 2 points. Each Temple = 2 points. Frame Front = 2 points. If you use all 10 replacement points before the expiration of the warranty period, you will be responsible for paying any additional repair or replacement costs. This warranty does not cover scratched lenses. Broken part(s) must be submitted to qualify for this replacement plan.

Vision Network Providers

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

Going to a participating vision network provider will reduce your out-of-pocket expenses. First of all, you will have no Co-payments or out-of-pocket expenses for covered vision services such as a routine vision exam, regular-size lenses, certain designated frames that cost less than \$60, or Medically Necessary contacts. Secondly, if you choose to upgrade your frame selection by selecting a more expensive frame, the retail price of the frame will be discounted. Finally, there are many popular non-covered lens features whose prices are limited or "capped" under the participating provider agreement.

In addition, participating providers can check on your eligibility, file your claim and be authorized by you to receive the reimbursement for covered services directly from the Vision Benefits Manager. Information about participating providers in your area is available by calling your Vision Benefits Manager.

Generally, if you choose to receive covered vision services from a non-participating vision provider you will have to pay the provider and file your own claim with the Vision Benefits Manager. The Vision Benefits Manager will reimburse you directly based on a fee schedule.

Claim forms are available upon request from SVS Vision or by visiting the following website: www.svsvision.com. Submit completed claim forms, along with your itemized receipt, to SVS Vision Managed Care, Inc. P.O. Box 464, Mt. Clemens, MI 48046-0464. You will be reimbursed up to the amounts described. If you or your eligible dependent receives vision care services from a network provider, no claim forms are required.

If you live more than 25 miles from a participating provider and choose to receive covered services from a non-participating provider, then your reimbursement will be based on the Allowed Amount as determined by the Vision Benefits Manager.

Contact SVS at 800-225-3095 if you have questions about limitations and exclusions.

Contact Information

Plans notated with an asterisk (*) may not be available in all geographic areas. Contact Retiree Health Care Connect for information.

Call Centers	
Retiree Health Care Connect (Eligibility Benefits Center)	877-829-9444
Pension Administrator	800-248-4444 National Employee Services Center
Medicare CMS/Centers for Medicare & Medicaid Services	Medicare Service Center: 800-MEDICARE (800-633-4227) Medicare Service Center TTY: 877-486-2048

Health Plan Carriers	Claim Inquiries	Appeals
Advantage HMO Indiana* 800-553-8933	Advantage HMO Indiana 9045 River Road, Suite 200 Indianapolis, IN 46240	Advantage HMO Indiana 9045 River Road, Suite 200 Indianapolis, IN 46240
AudioNet Hearing 877-500-7370	AudioNet Hearing P.O. Box 464 Mt. Clemens, MI 48046	AudioNet Hearing P.O. Box 464 Mt. Clemens, MI 48046
Blue Care Network HMO* 800-222-5992	Blue Care Network or BCN Advantage Member Reimbursement P.O. Box 68767 Grand Rapids, MI 49516-8767	Blue Care Network or BCN Advantage Attn: Appeals and Grievances Mail Code 248 P.O. Box 284 Southfield, MI 48037-9887
Blue Advantage HMO Illinois* 800-892-2803	Blue Advantage HMO P.O. Box 805107 Chicago, IL 60680-4112	Blue Advantage HMO P.O. Box 805107 Chicago, IL 60680-4112
Blue Care HMO Kansas City* 866-579-0864	Blue Cross Blue Shield of Kansas City 2301 Main Street P.O. Box 419169 Kansas City, MO 64141-6169	Blue Cross Blue Shield of Kansas City 2301 Main Street P.O. Box 417005 Kansas City, MO 64179-9773
Blue Cross Blue Shield Traditional Care Network (TCN) 877-832-2829	UAW Auto Retiree Service Center P.O. Box 311088 Detroit, MI 48231	UAW Auto Retiree Appeals Unit Mail Code 2004 Blue Cross Blue Shield of Michigan 600 Lafayette East Detroit, MI 48226-2998

Health Plan Carriers	Claim Inquiries	Appeals
Blue Preferred Plus PPO* 877-832-2829	UAW Auto Retiree Service Center P.O. Box 311088 Detroit, MI 48231	UAW Auto Retiree Appeals Unit Mail Code 2004 Blue Cross Blue Shield of Michigan 600 Lafayette East Detroit, MI 48226-2998
Delta Dental 800-524-0149	Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085	Delta Dental P.O. Box 30416 Lansing, MI 48909-7916
Green Shield* (Canada) 888-711-1119		
Health Alliance Plan (HAP) HMO* HMO: 800-422-4641 Medicare Advantage: 800-801-1770	HAP ATTN: Claims Department 2850 W. Grand Blvd. Detroit, MI 48202	HAP Vice President Client Services 2850 W. Grand Blvd. Detroit, MI 48202
Health Partners HMO Minnesota* 800-883-2177 (non-Medicare Retirees) 800-233-9645 (Medicare Retirees/Freedom Plan Participants)	Health Partners Medical Claims P.O. Box 1289 Minneapolis, MN 55440-1289	Health Partners Member Services P.O. Box 1309 Minneapolis, MN 55440-1309
Health Plus* 800-332-9161	Health Plus Claims 2050 S. Linden Road Flint, MI 48532	Health Plus Appeals 2050 S. Linden Road Flint, MI 48532
Home Medical Equipment (HME – formerly Northwood) (Durable Medical Equipment Benefit Manager) 888-722-0322	HME Claims P.O. Box 3078 Centerline, MI 48015-4117	HME National Network Auto National Appeals Unit P.O. Box 3078 Centerline, MI 48015-4117
Humana HMO* 800-758-5002	Humana Claims P.O. Box 14610 Lexington, KY 40512-4610	Humana Grievance & Appeals P.O. Box 14546 Lexington, KY 40512-4546

Health Plan Carriers	Claim Inquiries	Appeals
Kaiser Permanente HMO California* 800-464-4000	Northern California: Kaiser Permanente Attn: California Claims Administration Department P.O. Box 12923 Oakland, CA 94604-2923 Southern California: Kaiser Permanente Claims Administration Department P.O. Box 7004 Downey, CA 90242-7004	Submit orally or in writing to local member services department at plan facility. Expedited Review Unit: 888-987-7247 Fax 888-987-2252 Mon-Sat, 8:30-5 Kaiser Foundation Health Plan, Inc. Expedited Review Unit P.O. Box 23170 Oakland, CA 94623-0170
Kaiser Permanente HMO North West* 800-813-2000	Kaiser Foundation Health Plan of the NW Claims Administration 500 NE Multnomah St. Suite 100 Portland, OR 97232	Kaiser Foundation Health Plan of the NW (Grievance/Appeals) 500 NE Multnomah St. Suite 100 Portland, OR 97232-2099
Kaiser Permanente HMO Georgia* 888-865-5813	Kaiser Permanente Claims P.O. Box 190849 Atlanta, GA 31119-0849	Kaiser Permanente Appeals 3495 Piedmont Road NE Atlanta, GA 30305
Kaiser Permanente HMO Ohio* 800-686-7100	Kaiser Permanente Claims Department P.O. Box 5316 Cleveland, OH 44101-9774	Appeals Unit Kaiser Foundation Health Plan of Ohio P.O. Box 93764 Cleveland, OH 44101-5764
Kaiser Permanente HMO Colorado* 800-632-9700	Kaiser Permanente P.O. Box 373150 Denver, CO 80237-3150	Kaiser Permanente Member Services 2500 S. Havana St. Aurora, CO 80014 888-681-7878
Medco Health Solutions (Pharmacy Benefit Manager) 866-662-0274 www.medco.com	Medco Health Solutions 8111 Royal Ridge Parkway Irving, TX 75063	Medco Health Solutions Attn: Appeals Unit 8111 Royal Ridge Parkway Irving, TX 75063
Mercy Care HMO Wisconsin* 800-895-2421	Mercy Care HMO Claims P.O. Box 2770 Janesville, WI 53547-2770	Mercy Care HMO Appeals P.O. Box 2770 Janesville, WI 53547-2770
Midwestern Dental* 800-544-6374	Midwestern Dental Plans Inc. 5050 Schaefer Road Dearborn, MI 48126	Midwestern Dental Plans Inc. 5050 Schaefer Road Dearborn, MI 48126

Health Plan Carriers	Claim Inquiries	Appeals
Priority Health* 877-667-8619	Priority Health Claims P.O. Box 232 Grand Rapids, MI 49501-0232	Priority Health Claims Mail Stop 1145 1231 East Beltline Grand Rapids, MI 49525
SVS Vision 800-225-3095	SVS P.O. Box 464 Mt. Clemens, MI 48046	SVS P.O. Box 464 Mt. Clemens, MI 48046
TheraMatrix 888-638-8786	TheraMatrix Physical Therapy Network P.O. Box 321036 Detroit, MI 48232	TheraMatrix Physical Therapy Network P.O. Box 321036 Detroit, MI 48232
Univera* 800-337-3338	Univera Claims P.O. Box 23000 Rochester, NY 14692	Univera Appeals P.O. Box 23000 Rochester, NY 14692
Value Options (Behavioral Health Benefits Manager) 877-228-3912	Value Options 48561 Alpha Drive, Suite #150 Wixom, MI 48393-3442	Value Options 48561 Alpha Drive, Suite #150 Wixom, MI 48393-3442

This Schedule of Benefits is meant to be an easy-to-understand description of your program of health care benefits, but it does not replace the official Plan Document. If there is any conflict between the wording of the Plan Document and this Schedule of Benefits, the Plan Document governs.