Retiree Medical Insurance Plan Summary of Benefits *(NEPRIT M2)*

Underwritten by: Transamerica Premier Life Insurance Company

Calendar Year Deductible: **$300.00** *(Includes Part B Deductible)*
Part B Co-Insurance: **10%**
Annual Out-of-Pocket Maximum: **$1,300** *(Includes Calendar Year Deductible)*

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

Services	Medicare Pays	Plan Pays	You Pay
HOSPITAL CONFINEMENT BENEFIT* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but Part A Deductible	Part A Deductible	**$0**
61st through 90th day	All but Part A Coinsurance	Part A Coinsurance	**$0**
91st through 150th day (While using 60 lifetime reserve days)	All but Part A Coinsurance	Part A Coinsurance	**$0**
Once Lifetime Reserve days are used:			
Additional 365 days:	$0	100% of Medicare Eligible Expenses	**$0**
Beyond the Additional 365 days	$0	$0	**All costs**
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	**$0**
21st through 100th day	All but Part A Coinsurance	Part A Coinsurance	**$0**
101st day and after	$0	$0	**All costs**
BLOOD DEDUCTIBLE – Hospital Confinement and Out-Patient Medical Expense When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints	$0	3 pints	**$0**
Additional amounts	100%	$0	**$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	**Balance**

Retiree Medical Insurance Plan Summary of Benefits *(NEPRIT M2)*

Underwritten by: Transamerica Premier Life Insurance Company

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Services	Medicare Pays	Plan Pays	You Pay
OUT-PATIENT MEDICAL EXPENSES - - **In or Out of the Hospital and Out-Patient Hospital Treatment**, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
Medicare Part B Deductible: First Dollars of Medicare-approved amounts**	$0	$0	**Part B Deductible**
Next Dollars of Medicare-approved amounts	80%	$0	**20% until remaining Calendar Year Deductible has been met**
Additional Medicare-approved amounts	80%	10% until remaining Out-of-Pocket Max is met, then 20%	**10% until remaining Out-of-Pocket Max is met, then $0**
Part B Excess Charges (Above Medicare Approve Amounts)	$0	100%	**0%**
BLOOD			
First 3 pints	$0	All costs	**$0**
Next Dollars of Medicare Approved Amounts**	$0	$0	**Part B Deductible**
Next Dollars of Medicare-approved amounts	80%	$0	**20% until remaining Calendar Year Deductible has been met**
Additional Medicare-approved amounts	80%	10% until remaining Out-of-Pocket Max is met, then 20%	**10% until remaining Out-of-Pocket Max is met, then $0**
CLINICAL LABORATORY SERVICES			
Blood tests for Diagnostic Services	100%	$0	**$0**

MEDICARE PARTS A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE – Medicare Approved Services:			
Medically necessary skilled care services and medical supplies	100%	$0	**$0**
DURABLE MEDICAL EQUIPMENT			
First Dollars of Medicare Approved Amounts**	$0	$0	**Part B Deductible**
Next Dollars of Medicare-approved amounts	80%	$0	**20% until remaining Calendar Year Deductible has been met**
Additional Medicare-approved amounts	80%	10% until remaining Out-of-Pocket Max is met, then 20%	**10% until remaining Out-of-Pocket Max is met, then $0**

Retiree Medical Insurance Plan Summary of Benefits *(NEPRIT M2)*

Underwritten by: Transamerica Premier Life Insurance Company

OTHER BENEFITS NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	**$250**
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime max

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**Once you have been billed the first dollars of Medicare-Approved amounts for covered services (which are noted with two asterisks), your Medicare Part B Deductible will have been met for the calendar year.

Benefits are paid only for those expenses which have been approved as eligible by the federal Medicare program.

Benefits will not be paid for any expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

This policy's renewability, cancellability and termination provisions are at the option of the group policy holder except in cases of non-payment of premium

The summary of program benefits described herein is for illustrative purposes only. In case of differences or errors, the Group Policy governs.

2021 Prescription Drug Benefit Medicare Part D ENH 4T09

January 1, 2021 – December 31, 2021

Prescription Drug Benefits
Deductible and Limits on How Much You Pay for Covered Services

Annual Deductible

There is no deductible for Retiree RxCare. You begin in the Initial Coverage Stage when you fill your first prescription of the year.

Initial Coverage

You pay the following until your total yearly drug costs reach $4, 130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Tier	30 Day Retail Pharmacy Copay	90 Day Retail Pharmacy or Mail Order Copay
Tier 1	$10 .00	$20.00
Tier 2	$25.00	$50.00
Tier 3	$50.00	$150.00
Tier 4	25% coinsurance	25% coinsurance

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there may be a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4, 130.

With Retiree RxCare, after you enter the coverage gap, you will continue to pay your Initial Coverage Stage copayment amount for covered drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550

- **You pay the greater of:**
  - 5% of the cost, or
  - $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copay for all other drugs.
- **Our plan pays the rest of the cost of covered drugs.**

MONTHLY PAYMENT SUMMARY

ICUBA 2021 Retiree Medical Program	
Age	**Medical with Enhanced 4-Tier Rx**
65-69	**$398.48**
70-74	**$446.27**
75-79	**$466.21**
80-84	**$496.95**
85-89	**$521.43**
90+	**$532.05**

Rates above are effective from January 1, 2021 and are subject to change each year on January 1st. Rates are based on your age as of January 1, 2021.

If you have any questions regarding plan enrollment, benefits, or plan options please call the AmWINS Customer Care Center, Monday through Friday from 8:00 AM to 8:00 PM (Eastern): **1.888.883.3757**

RETIREE MEDICAL PLAN ELECTION FORM

ICUBA

Medical plan is underwritten by: Transamerica Premier Life Insurance Company
National Employers Professional Retirees Insurance Trust

You must return your election form to put your coverage in force!			
Retiree Information (Please print)			
Name		Date of Birth	
Address		Social Security Number	
City		Medicare ID# (From Medicare Id card)	
State	Zip Code	Sex	Phone Number
Email Address		Date of Retirement	
Spouse Information (if enrolling)			
Name		Date of Birth	
Sex		Social Security Number	
Date of Retirement		Medicare ID #(From Medicare ID card)	

Please Choose Type of Coverage			
Effective Date: __/1/2021 **Check Desired Coverage:**	**Retiree Only**	**Retiree & Spouse**	**Surviving Spouse**
Medical Plan NEPRIT M2			

(continued on reverse)

Please Complete the Following Information:

RETIREE MEDICAL PLAN ELECTION FORM

Do you (or your spouse, if enrolling) currently have any Medicare Supplement policies or certificates in force (including Health Maintenance Organization contract or Health care service contract)?

Retiree (if enrolling): ☐ Yes ☐ No Spouse (if enrolling): ☐Yes ☐No

a) If YES*, with which company? _____

b) What kind of policy / certificate? _____

c) Length of time you have had coverage? _____ Years_____ Months_____

d) Will you be replacing the above listed policy/certificate upon acceptance of this enrollment form?
☐ Yes ☐ No

*I understand it is my responsibility, if I desire to do so, to cancel my current coverage, if any, by notifying the Provider or Plan Administrator of such coverage.

FRAUD WARNING

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Fraud Warning:

AR, CO, KY, LA, ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

MD Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD1000A.MD.

DC Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(continued on next page)

RETIREE MEDICAL PLAN ELECTION FORM

Release of Information:
By joining this medical and Medicare prescription drug plan, I acknowledge that my information will be released to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled.

I understand that my signature (or that of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that this person is authorized under State law to complete this enrollment and documentation of this authority is available upon request by Medicare.

Date:	**Retiree Signature:**
Date:	**Spouse/Surviving Spouse Signature:**

If you are an authorized representative, you must sign above and provide the following information:

Name:_____

Address:_____

Phone Number:_____

Relationship to Retiree:_____

Please return signed election form to:
AmWINS Group Benefits
50 Whitecap Drive, North Kingstown, RI 02852

For Customer Service, please call: 1-888-883-3757
Monday through Friday, 8:00 AM to 8:00 PM EST

Retiree Rx Care

PRESCRIPTION DRUG PLAN

Enrollment Form for Plans Underwritten by Elixir Insurance Company
Please provide the following information and sign the last page of this form.

ICUBA **Effective Date: ____ /01/2021**

Retiree		
Name:	Gender: ☐ M ☐ F	Birth Date:
Street Address:		
City:	State:	Zip:
Social Security Number:	Phone Number:	
Medicare ID # *(from Medicare ID card):*		
Hospital (Part A) effective date *(from Medicare ID card):*		
Medical (Part B) effective date *(from Medicare ID card):*		
Email Address:		
Spouse or Surviving Spouse		
Name:	Gender: ☐ M ☐ F	Birth Date:
Street Address:		
City:	State:	Zip:
Social Security Number:	Phone Number:	
Medicare ID # *(from Medicare ID card):*		
Hospital (Part A) effective date *(from Medicare ID card):*		
Medical (Part B) effective date *(from Medicare ID card):*		
Email Address:		
Alternative Contact (Optional)		
Name:		
Phone Number:	Relationship to you:	
Select Your Enrollment Options Below (Please Check Desired Coverage)		
Please check which plan you want to enroll in:		
Retiree: ☐ 4-Tier Rx Plan (ENH 4-T09)	**Spouse or Surviving Spouse:** ☐ 4-Tier Rx Plan (ENH 4-T09)	

(Continued on next page)

Retiree RxCare

Please Answer the Following Questions to Help Medicare Coordinate Your Benefits:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Retiree RxCare? ☐ Yes ☐ No
If "yes:, please list your other coverage and your identification (ID) number(s) for this coverage below:

Name of other coverage:	ID # for this coverage:	Group # for this coverage:

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "yes", please provide the following information:

Name of Institution:

Address (number and street) & Phone Number of Institution:

Please Read This Important Information:

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage Plan that will meet your needs. By joining Retiree RxCare your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from another employer or union, i.e., through your spouse or another former employer, joining Retiree RxCare could affect your employer or union health benefits. If you have health coverage from another employer or union, and you enroll in Retiree RxCare, we may coordinate the benefits between your other plan and Retiree RxCare. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read This Important Information and Sign Below:

By completing this enrollment application, I agree to the following:

Retiree RxCare (PDP) is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Elixir Insurance Company of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. If I am currently in a Medicare Prescription Drug Plan, my enrollment in the PDP will end that enrollment. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Elixir Insurance Company or by calling 1-800-Medicare, 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

Retiree RxCare is a national employer group so if I move out of state, I can remain enrolled in the plan. I will notify the Plan of my address change. Once I am a member of Retiree RxCare, I have the right to appeal plan decisions about payment or services with which I disagree. I will read the Evidence of Coverage document from Retiree RxCare when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

Retiree RxCare

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge Elixir Insurance Company will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Elixir Insurance Company will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I reside) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Elixir Insurance Company or by Medicare.

Retiree's Signature:	**Today's Date:**
Spouse or Surviving Spouse's Signature:	**Today's Date:**

Please complete this section: To the best of my knowledge, the information on this form is true and correct.	
Signature:	Date:

If you are the authorized representative, you must provide the following information:
Name:
Address:
Phone Number:
Relationship to Enrollee:

Medicare Prescription Drug Use Only:			
Plan ID#			
Effective Date of Coverage:	IEP:	AEP:	SEP (type):
Plan Representative Signature:			