ICUBA

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 $1,316	$1,316 (Part A Deductible)	**$0**
61st through 90th day	All but $329 per day	$329 per day	**$0**
91st through 150th day (While using 60 lifetime reserve days)	All but $658 per day	$658 per day	**$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 $164.50 a day	Up to $164.50 a day	**$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**

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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 $183 of Medicare-approved amounts**	$0	$0	**$183 (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 $183 of Medicare Approved Amounts**	$0	$0	**$183 (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**

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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 $183 of Medicare Approved Amounts**	$0	$0	**$183 (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**

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

The Medicare Parts A and B deductibles and co-insurance amounts shown are the 2017 amounts. Your plan will automatically adjust to the changes to Medicare Parts A and B amounts for 2018.

2018 Prescription Drug Plan Summary

Underwritten by Transamerica Life Insurance Company

Medicare GenerationRx ™ (Employer PDP) 4-Tier Medicare Part D Plan

This plan offers a four-tier co-payment plan for prescription drugs. This is a plan with no annual deductible. You will be responsible for a co-payment for your prescription drugs. If your out-of-pocket costs reach $5,000 ("Catastrophic Limit") your co-payment will be reduced to the greater of a $3.35 co-payment for generic drugs (including brand drugs treated as generic) and a $8.35 co-payment for all other drugs, or a 5% co-insurance.

Medicare GenerationRx Medicare Part D Plan			
Deductible:	**$0.00**		
Copay:	**Retail (31 Days)**	**Retail (90 Days)**	**Mail Order (90 Days)**
Generic Tier	**$10**	**$20**	**$20**
Preferred Brand Tier	**$25**	**$50**	**$50**
Non-Preferred Brand Tier	**$50**	**$150**	**$150**
Specialty Tier	**50%**	**50%**	**Only Available in Retail**
Coverage in Gap * :	**Same copay schedule as above**		

*After your total yearly drug costs reach $3,750, you will pay the same copay schedule as noted above. The co-payments shown already include the manufacturer discounts on brand name drugs by the Medicare Coverage Gap Discount Program.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the Coverage Gap and are not already receiving "Extra Help". The amount discounted by the manufacturer counts toward your out-of-pocket costs as if you had paid this amount and moves you through the Coverage Gap.

Medicare GenerationRx is underwritten by Transamerica Life Insurance Company, an employer group waiver plan and PDP with a Medicare contract. Enrollment in this plan depends on contract renewal. The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

MONTHLY PAYMENT SUMMARY

ICUBA Retiree Medical Program	
Age	**Medical with Enhanced 4-Tier Rx**
65-69	**$466.06**
70-74	**$509.82**
75-79	**$528.08**
80-84	**$556.23**
85-89	**$578.65**
90+	**$588.37**

Rates above are effective from January 1, 2018 to December 31, 2018 and are subject to change each year on January 1st. Rates are based on your age as of January 1, 2017.

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 & PRESCRIPTION DRUG PLAN ELECTION FORM

ICUBA

Medical plan is underwritten by: Transamerica Premier Life Insurance Company
Prescription Drug Plan is underwritten by: Transamerica Life Insurance Company as Medicare GenerationRx (Employer PDP)
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: __/1/18 **Check Desired Coverage:**	**Retiree Only**	**Retiree & Spouse**	**Surviving Spouse**
Medical Plan & Prescription Drug Plan	☐	☐	☐

(continued on reverse)

RETIREE MEDICAL & PRESCRIPTION DRUG PLAN ELECTION FORM

Please Complete the Following Information:

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.

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RETIREE MEDICAL & PRESCRIPTION DRUG 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.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this form means that I have read and understand the contents of the Medicare GenerationRx (Employer PDP) Important Information about Your Prescription Drug Coverage document.

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:_____