Benefits for
Fiat Chrysler Automobiles Retirees
c/o Amwins Group Benefits, LLC
50 Whitecap Drive
North Kingstown, RI 02852

Fiat Chrysler Automobiles Retirees

Retiree Medical Program

Your 2024 Retiree Health Benefits

2024 Medicare Retiree Healthcare Benefits

Retirees of FCA US LLC (FCA), a part of the Stellantis family of companies are eligible to participate in a custom Medicare Supplement & Prescription Drug Plan once you (and/or your spouse) enroll in Medicare Parts A & B. This program began in 2007 and continues to insure thousands of FCA Medicare retirees and their spouses today.

The program is administered by Amwins Group Benefits, LLC. Amwins is a company that has been specializing in retiree healthcare benefits since 1991. Our dedicated Retiree Customer Care Center is staffed with experienced insurance professionals who are familiar with your health insurance plan options and sensitive to your needs. They are always just a phone call away and are happy to review any of the information in the enclosed enrollment kit with you.

Before you begin to review the information in this kit, you should be aware of some of the critical advantages available to you. They include:

- Coverage is available on a "Guaranteed Acceptance" basis with no Medical Questions or Medical Underwriting requirements. You will enjoy go-anywhere-care coverage. There are no provider networks to limit your choice of doctors, and no provider referrals are necessary (unlike PPO and HMO plans). Just be sure your provider accepts Medicare and you're all set.
- Your medical insurance will be insured by Transamerica Life Insurance Company (A.M. Best rated "A+").
- Your Medicare Part D insurance will be provided by Retiree Rx Care, insured by Elixir Rx Insurance (a subsidiary or Rite Aid). The prescription coverage is a 'creditable' Medicare Part D plan with full coverage through the coverage gap or "donut hole." 99 of the top 100 drugs utilized are covered by the plan. You may call 1-866-847-5820 to verify that your prescription drugs are covered. There are over 67,000 participating pharmacies including CVS, Walgreens, Wal-Mart, Kmart, Kroger, Eckerd, King Super, Rite-Aid, Winn Dixie, Publix, Target and many more. There are no "mandatory generic use" rules either.
- There is no paperwork to file when using either plan. Just show your insurance cards, and your claims will be processed electronically by your providers.
- There are also dental and vision options available to you. You must elect a medical plan through Amwins to be eligible for the dental and/or vision plans.
- Amwins can notify your HRA administrator (if applicable) of your premium payments so you can receive an automatic reimbursement. This way you do NOT have to submit your Health Care premiums for reimbursement monthly.

Our dedicated Retiree Customer Care Center means you can speak with a knowledgeable professional dedicated to help you and advocate for you.

With all these advantages in mind, we invite you to study the enclosed enrollment kit. This complete kit includes valuable healthcare information and instructions to help you select the plan that best meets your healthcare needs. Once we receive your completed enrollment forms and first month's premium payment, we will arrange your plan documents and applicable ID cards. You have a choice of two ways to pay future premiums. You may pay monthly by Electronic Funds Transfer (EFT) from your bank account, or by check paid directly to Amwins.

Please be sure to review the contents of this package and return your completed enrollment forms in the enclosed, postage-paid return envelope. If you are enrolling your spouse, age 65 or over, be sure to complete the spouse's information section as well.

We look forward to serving you and assure you that your health plan is in excellent hands with Amwins as your administrator. If you have any questions, please feel free to call our Customer Care Center at 1-866-847-5820.

Amwins Customer Care Center

MEDICAL SUMMARY

Plan 1 ($800 Out-of-Pocket Maximum)

Underwritten by Transamerica Premier Life Insurance Company

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization*: 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 Daily Copay	All but Daily Copay	**$0**
91st day and after: While using 60 lifetime reserve days:	All but Daily Copay	All but Daily Copay	**$0**
Additional 365 days:	$0	100% of Medicare-Eligible expenses	**$0**
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 Daily Copay	All but Daily Copay	**$0**
Blood:			
First 3 pints	$0	All Costs	**$0**
Additional Amounts	100%	$0	**$0**
Hospice Care: Available as long as your doctor certifies that 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**
*A benefit period begins on the first day you receive services 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.			

MEDICARE (PART B)- MEDICAL SERVICES-PER CALENDAR YEAR			
Maximum Out-of-Pocket: You pay the Plan Deductible of $300 and 20% coinsurance until you pay $800* out of pocket, then the plan pays 100% of Medicare-approved amounts.			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses: In or Out of the Hospital and Outpatient 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:			
First $300 of Participant Charges**	$0	$0	**$300 (Plan Deductible)**
Remainder of Medicare-approved amounts	80%	$0	**20% (until $800* max is met, then $0)**
After the Maximum Out of Pocket (Total $800)	80%	20%	**$0**
Blood			
First 3 pints	$0	All Costs	**$0**
Additional Amounts	100%	$0	**$0**
Clinical Laboratory Services			
Blood tests for Diagnostic Services	100%	$0	**$0**
*Once you pay the $800 out-of-pocket maximum per Calendar year, the Plan pays 100% for these services. **This amount includes your annual Part B deductible and is included in the Out-of-Pocket Maximum.			

MEDICAL SUMMARY

Plan 1 ($800 Out-of-Pocket Maximum)

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*: Medicare-approved amounts	80%	$0	**20% (until $800* max is met, then 0%)**
Preventive Medical Care: Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services and any other tests or preventative measures determined to be appropriate by the attending physician.			
Pap Test and Pelvic Examination (Includes Clinical Breast Exam) Once during a calendar year	100% of Pap lab test, 80% for Pap test collection and pelvic and breast exam	Any remaining usual and customary charges incurred after Medicare has paid	**$0**
Annual Wellness Visit	100%	$0	**$0**
Prostate Cancer Screening (Once during a calendar	For men 50 and older, 80% of the Medicare- approved amount for the digital rectal exam after the yearly	100% of the usual and customary charges incurred after Medicare has paid	**$0**
Mammogram Screening (Once during a calendar year)	80% of the Medicare-approved amount	100% of the usual and customary charges incurred after Medicare has paid	**$0**
Foreign Travel Benefit: Medically necessary emergency care services beginning during the first 60 days of each trip outside the			
First $250 of each calendar year	$0	$0	**$250**
Remainder of charges	$0	80% to a lifetime max. of $50,000	**20% and amounts over the $50,000**
*Once you pay $800 out-of-pocket maximum per Calendar year, the Plan pays 100% for these services			
Epic Discount Hearing Plan	$0	**Discount Only**	

*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.

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.

MEDICAL PREMIUM RATES		
Benefit Period	**Retiree Only**	**Retiree and Spouse**
January 1, 2024 - December 31, 2024	**$229.65**	**$459.30**

Note: If you are a surviving spouse, you will be billed the "retiree only" rate.

MEDICAL SUMMARY

Plan 2 ($1,300 Out-of-Pocket Maximum)

Underwritten by Transamerica Premier Life Insurance Company

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization*: 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 Daily Copay	All but Daily Copay	**$0**
91st day and after: While using 60 lifetime reserve days:	All but Daily Copay	All but Daily Copay	**$0**
Additional 365 days:	$0	100% of Medicare-Eligible expenses	**$0**
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 Daily Copay	All but Daily Copay	**$0**
Blood:			
First 3 pints	$0	All Costs	**$0**
Additional Amounts	100%	$0	**$0**
Hospice Care: Available as long as your doctor certifies that 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**
*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.			

MEDICARE (PART B)- MEDICAL SERVICES-PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses: In or Out of the Hospital and Outpatient 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:			
First $300 of Participant Charges**	$0	$0	**$300 (Plan Deductible)**
Remainder of Medicare-approved amounts	80%	$0	**20% (until $1,300* max is met, then 0%)**
After the Maximum Out of Pocket (Total $1,300)	80%	20%	**$0**
Blood			
First 3 pints	$0	All Costs	**$0**
Additional Amounts	100%	$0	**$0**
Clinical Laboratory Services			
Blood tests for Diagnostic Services	100%	$0	**$0**
*Once you pay the $1,300 out-of-pocket maximum per Calendar year, the Plan pays 100% for these services. **This amount includes your annual Part B deductible and is included in the Out-of-Pocket Maximum.			

MEDICAL SUMMARY

Plan 2 ($1,300 Out-of-Pocket Maximum)

Underwritten by Transamerica Premier Life Insurance Company

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*: Medicare approved amounts	80%	$0	**20% (until $1,300* max is met, then 0%)**
Preventive Medical Care: Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services and any other tests or preventative measures determined to be appropriate by the attending physician.			
Pap Test and Pelvic Examination (Includes Clinical Breast Exam) Once during a calendar year	100% of Pap lab test, 80% for Pap test collection and pelvic	Any remaining usual and customary charges incurred after Medicare	**$0**
Annual Wellness Visit	100%	$0	**$0**
Prostate Cancer Screening (Once during a calendar year)	For men 50 and older, 80% of the Medicare approved amount for the digital rectal exam after the yearly Part B deductible	100% of the usual and customary charges incurred after Medicare has paid	**$0**
Mammogram Screening (Once during a calendar year)	80% of the Medicare-approved amount	100% of the usual and customary charges incurred after Medicare has paid	**$0**
Foreign Travel Benefit: Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 of each calendar year	$0	$0	**$250**
Remainder of charges	$0	80% to a lifetime max. of $50,000	**20% and amounts over the $50,000 lifetime max**
*Once you pay $1,300 out-of-pocket maximum per Calendar year, the Plan pays 100% for these services.			
Epic Discount Hearing Plan	$0	**Discount Only**	

*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.

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.

MEDICAL PREMIUM RATES		
Benefit Period	**Retiree Only**	**Retiree and Spouse**
January 1, 2024 - December 31, 2024	**$196.20**	**$392.40**

Note: If you are a surviving spouse, you will be billed the "retiree only" rate.

Retiree RxCare

PRESCRIPTION DRUG SUMMARY-OPTION 1

January 1, 2024 – December 31, 2024

Deductible and Limits on How Much You Pay for Covered Services

Annual Deductible

$545 Per Calendar Year

Initial Coverage

You pay the following until your total yearly drug costs reach **$5,030.** 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	$15.00	$30.00
Tier 2	$50.00	$100.00
Tier 3	$100.00	$200.00
Tier 4	25%	25%

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 **$5,030.**

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 **$8,000,** which is the end of the coverage gap. Not everyone will enter the coverage gap.

*Your Coverage Gap copay already includes the manufacturer's discount on covered brand name drugs to Part D enrollees not already receiving extra help.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$8,000, you will pay $0.00,**

PRESCRIPTION DRUG PREMIUM RATES		
Benefit Period	**Retiree Only**	**Retiree and Spouse**
January 1, 2024 – December 31, 2024	**$201.37**	**$402.74**

PRESCRIPTION DRUG SUMMARY-OPTION 2

January 1, 2024 – December 31, 2024

Deductible and Limits on How Much You Pay for Covered Services

Annual Deductible

$0 Per Calendar Year

Initial Coverage Level

You pay the following until your total yearly drug costs reach **$5,030.** 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	25%	25%
Tier 2	25%	25%
Tier 3	25%	25%
Tier 4	25%	25%

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 **$5,030.**

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 **$8,000,** which is the end of the coverage gap. Not everyone will enter the coverage gap.

*Your Coverage Gap copay already includes the manufacturer's discount on covered brand name drugs to Part D enrollees not already receiving extra help.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$8.000. vou will pay $0.00**

PRESCRIPTION DRUG PREMIUM RATES		
Benefit Period	**Retiree Only**	**Retiree and Spouse**
January 1, 2024 – December 31, 2024	**$145.30**	**$290.60**

MONTHLY PAYMENT SUMMARY

2024 Monthly Rates

Plan Options	Retiree Only	Retiree & Spouse	Surviving Spouse
Option 1 High Option Medical Plan 1 Only	**$229.65**	**$459.30**	**$229.65**
Option 2 Low Option Medical Plan 2 Only	**$196.20**	**$392.40**	**$196.20**
Option 3 High Option Plan 1 Medical & Option 1 Enhanced Rx	**$431.02**	**$862.04**	**$431.02**
Option 4 Low Option Medical Plan 2 & Option 2 Basic Rx	**$341.50**	**$683.00**	**$341.50**

"The information in this payment summary is for general information purposes only. Amwins assumes no responsibility for any errors or omissions to the content or accuracy of these materials. Any questions regarding the payment amounts should be directed to the Amwins Customer Care Center. "

OPTIONAL DENTAL & VISION SUMMARY

(You must elect a medical plan to enroll in a dental and/or vision plan.)

PERSONAL DENTAL PLANS		
Dental Benefits	**Choice Plan Pays**	**Plus Plan Pays**
Class A - Preventive: Initial & Periodic Exams (2 per year); Cleanings (2 per year); Fluoride treatments (to age 16); Space Maintainers		
Waiting Period Co-Insurance	None 100%	None 100%
Class B - Basic: X-rays; Fillings; Simple Extractions		
Waiting Period* Coinsurance	None* 80%	None* 50%
Class C - Major: Oral Surgery; Endodontics; Periodontics; Crowns, Bridges, Dentures		
Waiting Period* Co-Insurance	None* 50%	None* 50%
Calendar Year Deductible - $50 Calendar Year Maximum for Classes A, B and C combined	$1,000	$1,000
Class A, B & C Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply.		
Optional Vision Benefits Rider (Not a Stand-alone Benefit)	**Choice Plan Pays**	**Plus Plan Pays**
Class A - Vision Exams - 1 per year		
Benefit Year One and Each Benefit Year Thereafter Waiting Period	85% None*	85% None*
Class B - Lenses and Frame - 1 pair every 2 years		
Benefit Year One and Each Benefit Year Thereafter Waiting Period	50% None*	50% None*
Class C - Contact Lenses - 1 pair every 2 years (in lieu of frames and lenses)		
Benefit Year One and Each Benefit Year Thereafter Waiting Period	50% None*	50% None*
Calendar Year Deductible	$50/Year	$50/Year
Calendar Year Maximum for Classes A, B and C	$150	$150

***This plan does include a 6 month waiting period for Basic Services and an 18 month waiting period for Major Services (as identified in the Certificate). A 15 month waiting period also applies to the Optional Vision Rider for Class B and Class C Services." Waiting periods will apply to any individuals who enroll for coverage after their initial 31 days of eligibility. The dental plan provides benefits for covered dental services rendered by any licensed dentist, physician or dental hygienist.**

The vision plan provides benefits for covered vision services rendered by an optometrist, ophthalmologist or optician.

QUESTIONS? PLEASE CONTACT Amwins CUSTOMER CARE AT 1-866-847-5820
Underwritten by: Ameritas

MONTHLY DENTAL/VISION COST SUMMARY

Monthly Rate Table-Countrywide

Plan Type	Coverage Type	area 1	area 2	area 3	area 4	area 5	area 6	area 7	area 8
Choice Plan	Applicant Only	$36.94	$40.63	$44.33	$49.13	$53.93	$59.10	$65.01	$71.66
	Applicant & Spouse	$73.87	$81.26	$88.64	$98.25	$107.85	$118.19	$130.01	$143.31
Plus Plan	Applicant Only	$30.71	$33.78	$36.85	$40.84	$44.84	$49.14	$54.05	$59.58
	Applicant & Spouse	$61.42	$67.56	$73.70	$81.69	$89.67	$98.27	$108.10	$119.15
Optional vision Coverage	Applicant Only	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00
	Applicant &	$13.00	$13.00	$13.00	$13.00	$13.00	$13.00	$13.00	$13.00

Zip Code Chart

State	Zip/Area	State	Zip/Area	State	Zip/Area	State	Zip/Area	State	Zip/Area	State	Zip/Area	State	Zip/Area	State	Zip/Area	State	Zip/Area
Alabama		**California**		**Colorado**		**Idaho**		**Kansas**		**Minnesota**		**Nebraska**		**N. Dakota**		**Pennsylvania**		**Utah**	
350-355	3	900-905	7	803		All Areas	1	660-662	2	553-558	2	All Areas	1	580-581	2	170-178	2	All Areas	1
359	3	906-914	6	808-810		**Illinois**		All Other	1	564, 566	2	**Nevada**		All Other	1	182-187	2	**Washington**	
All Other	1	915-916	8	All Other		600-605	2	**Kentucky**		All Other		890-891	2	**Ohio**		190-192	3	982-984	4
Alaska		917-918	4	**Delaware**		606-608	3	All Areas	1	**Mississippi**		894-895	6	All Areas	1	All Other	1	990-992	3
995-996		919-927	6	All Areas		All Other	1	**Louisiana**		390-392		898	6	**Oklahoma**		**S. Carolina**		993	6
All Other	8 6	930-934 939	6 6	**Dist. Columbia**		**Indiana**		707-711	2	All Other		All Other	4	740-743	2	All Areas	1	All Other	5
		943-948	4	All Areas		463-464	2	712	3					All Other	1				
Arizona		949, 961	6			473	3	All Other	1	**Missouri**		**New Mexico**				**Tennessee**		**W. Virginia**	
856-857	2	956-958	3	**Georgia**		All Other	1			640-641		881	2	**Oregon**		373-374	2	255-257	4
864	2	959	4	300-303				**Michigan**		644-649		882	5	977	3	All Other	1	262-265	3
All Other	1	All Other	5	All Other		**Iowa**		480-483	2	All Other		All Other	1	978	1	**Texas**		All Other	2
Arkansas				**Hawaii**		All Areas	1	490-491	2	**Montana**		**North**		All Other	2	751-753	3	**Wisconsin**	
All Areas	1			All Areas				488-489	3	590-591		277	2			754	4	All Areas	1
								All Other	1	599		286	3			756-757	1	**Wyoming**	
										All Other		287-289	2			776-777	1	All Areas	1
												All Other	1			All Other	2		

Monthly Rate Table for CT, MA, ME, MD, NH, NJ,RI

Plan Type	Coverage Type	area 1	area 2	area 3	area 4	area 5	area 6	area 7	area 8
Choice Plan	Applicant Only	$38.60	$42.46	$46.32	$51.34	$56.36	$61.76	$67.94	$74.88
	Applicant + Spouse	$77.19	$84.91	$92.63	$102.66	$112.70	$123.50	$135.85	$149.75
Plus Plan	Applicant Only	$32.37	$35.61	$38.84	$43.05	$47.26	$51.79	$56.97	$62.80
	Applicant + Spouse	$64.74	$71.21	$77.69	$86.10	$94.52	$103.58	$113.94	$125.60
Optional vision	Applicant	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00
	Applicant + Spouse	$13.00	$13.00	$13.00	$13.00	$13.00	$13.00	$13.00	$13.00

Zip Code Chart		
State	Zip	area
CT		5
MA		5
ME		1
MD	206-207	2
	209-211	2
	217	3
	all others	4
NH		1
NJ		4
RI		3

Calculating Your Rate: Locate the first 3 digits of your zip code on the Zip Code Area Chart. Use the corresponding area number to determine the applicable monthly premium in the Monthly Rate Table based upon your plan selection and coverage type.

	Applicant Only	Applicant & Spouse	Total Monthly Rate
Choice Plan:			
Plus Plan:			
Optional vision			

ANSWERS TO YOUR QUESTIONS

Q: Who can I call with questions?
A: Please contact Amwins Group Benefits' Customer Care Center *toll-free* at 1-866-847-5820, Monday through Friday, from 8 a.m. to 8 p.m. EST.

Q: How does the plan work?
A: The original Medicare plan has coverage gaps, which are the costs that you must pay, like coinsurance, co-payments, and deductibles. This plan helps fill those gaps. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and then your plan pays based on your plan's benefits. Following healthcare services, you will receive a Medicare Explanation of Benefits (EOB) in the mail (in most cases each month), including information on the amount paid on your behalf.

Q: Can my age 65 spouse enroll if I am not yet age 65? A:
Yes. As long as your spouse is eligible to participate in the program and is age 65 or over. As soon as you become Medicare eligible, you can enroll on the first day of the month in which you reach your 65th birthday.

Q: Do I still need my Medicare ID Card?
A: Yes. You will continue to use your Medicare ID card with this plan in conjunction with your Plan ID card.

Q: Will I have to re-enroll in the Plan next year?
A: No, once you enroll, you remain in the plan until you elect or terminate coverage. If you do not pay your monthly payment, your coverage will be canceled.

Q: When will I receive my ID Cards?
A: ID cards may arrive in two separate mailings following the processing of your enrollment forms and payment.

Q: How are my medical claims paid?
A: As long as your physician accepts Medicare you will not have to send in any claim forms. Present your ID card along with your Medicare card to your doctor. Medicare pays the provider of the Medicare portion of your claim and forwards the balance due to the claims administration department. Remaining amounts will be billed to you.

Q: What services are not covered?
A: Services not covered by Medicare are not covered by this plan. Please contact us for the Medicare exclusion list. You may also call 1-800-MEDICARE or visit the Medicare website at www.medicare.gov.

Q: Do my prescription drug co-payments count toward my medical plan deductible?
A: No. Any co-payments you make for prescription drugs do not count toward deductibles or out of pocket maximum amounts for medical plan.

Q: How do I get my prescriptions filled?
A: Simply present your ID card and prescription to a participating pharmacy in the plan network. You will also receive information about mail order prescriptions when you enroll. You can find more information about your prescription coverage by visiting www.retireerxcare.amwins.com or by calling Amwins Group Benefits at 1-866-847-5820.

Q: Where can I get information on using Mail Order Services? A:
Once you enroll in the plan, you will receive a fulfillment kit in the mail which will include mail order information from the Mail Service Pharmacy for Retiree RxCare. Please be aware that you will need to obtain new prescriptions from your doctor before ordering prescriptions from this new mail order program. The necessary forms and instructions on how to order prescriptions through the mail order service will be included in your fulfillment packet. Please expect your package and materials to arrive shortly before your plan effective date.

Q: How can I lower my drug expenses?
A: Generic medications often cost less than brand-name counterparts. Talk to your doctor to determine if a generic is available. You may also have the option of mail order, where you can receive up to a 90-day supply for one mail order co-payment.

Q: How can I find out if my drugs are covered on the new plan?
A: Visit www.retireerxcare.amwins.com or by call Amwins Group Benefits at 1-866-847-5820. Some covered drugs may have additional requirements or limits on coverage If your drug is not included on the formulary, you should first contact us and ask if your drug is covered. Please contact Amwins Group Benefits Customer Care toll-free at 1-866-847-5820 for more information about your prescriptions.

Q: How do I pay my monthly premium?

All premiums for this coverage will be eligible for reimbursement from your Fiat Chrysler Health Care Retirement Account. You may pay by Electronic Funds Transfer (EFT) from your checking account directly to Amwins (billing administrator for Transamerica). Your premiums are deducted on the date elected on your authorization form.

RETIREE MEDICAL & PRESCRIPTION DRUG PLAN ENROLLMENT FORM (CW)

Fiat Chrysler Automobiles Retirees
Medical plan is underwritten by: Transamerica Life Insurance Company
Prescription Drug Plan is underwritten by: Elixir Rx Insurance through Retiree RxCare

Effective Date:

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		Gender	Phone Number
State	Zip Code	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		Date of Retirement	
Spouse Information (if enrolling)			
Name		Date of Birth	
Gender		Social Security Number	
Date of Retirement		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			

Please Choose Type of Coverage			
***Check Desired Coverage*:**	**Retiree Only**	**Retiree & Spouse**	**Surviving Spouse**
Option 1 High Option Medical Plan 1 Only			
Option 2 Low Option Medical Plan 2 Only			
Option 3 High Option Medical & Enhanced Rx			
Option 4 Low Option Medical & Basic Rx			

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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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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 Retiree RxCare (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:_____

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

For Customer Service, please call: 1-866-847-5820
Monday through Friday, 8:00 AM to 8:00 PM EST

DENTAL/VISION APPLICATION

(You must enroll in a medical plan to elect a dental and/or vision plan.)

Dental application: Questions – Call 866-847-5820	Mail completed form to: Amwins /Fiat Chrysler Automobiles Retirees 50 Whitecap Drive North Kingstown, RI 02852	**FOR COMPANY USE ONLY** **Effective Date:** _____/_____/_____ **Plan Code:** _____

APPLICANT INFORMATION (PLEASE PRINT CLEARLY)

Last Name	First Name		Initial	Birth Date (M/D/Y): / /
Address	City	State	Zip	Marital Status ☐ Married ☐ Single
Telephone Number	Social Security Number		Sex: ☐ M ☐ F	
Billing Address (If Different)		City	State	Zip
Spouse's Name (First, Last, Middle Initial)			Spouse's Social Security Number	

LIST ALL OF YOUR ELIGIBLE DEPENDENTS BELOW

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y

Plan Selection: ☐ Choice ☐ Plus ☐ Vision Option Coverage for: ☐ Applicant Only ☐ Applicant and Spouse

Does Spouse have a dental plan: ☐ Yes ☐ No If yes, name of Plan:

By my signature below, I hereby apply for coverage under Group Dental Insurance Policy Form GH-1112 issued to the Voluntary Group Trust. I also certify I have read the applicable Fraud Notice on the last page.

_____ _____

Applicant Signature Date

IMPORTANT INFORMATION - upon receipt of your completed application you will receive a copy of your Certificate of Insurance and Identification Card(s). Do not cancel any other dental coverage you may have until you receive written confirmation from Ameritas. Please allow 3-4 weeks for processing.

FOR AGENT USE ONLY - Please Print Clearly

Producer Name: **Amwins**
Street Address: **50 WHITECAP DRIVE**
City: **NORTH KINGSTOWN** St: **RI** Zip: **02852**

Phone: **1-866-847-5820**
GH-1112-38870

NOTES

The benefit information contained in this brochure is subject to change at any time, and Fiat Chrysler Automobiles reserves the unlimited right to make benefit plan changes at any time. Any changes to the benefit plans implemented by the company will be considered effective, regardless of whether notice has been given, on the date set by the company. If you are ever in doubt about your retiree medical benefits, please contact Amwins Group Benefits, LLC. at 1-866-847-5820