c/o Amwins Group Benefits
50 Whitecap Drive
North Kingstown, RI 02852

United Service Workers Union

Your Retiree Medical Program Benefits

Your Retiree Medical and Prescription Drug Plan Benefits

Having quality health insurance is of utmost importance. To provide the best insurance value available, factoring coverage, service and price, United Service Workers Union (USWU) is pleased to offer a new Post-65 Retiree Medical Program to members of the USWU retiree chapter. Your Medicare eligible spouse is also eligible to join the USWU Retiree Chapter and have access to the enclosed benefits. To participate, you must be a member of the USWU Retiree Chapter, 65 or older, no longer working and enrolled in Medicare Parts A & B prior to your enrollment effective date. USWU has informed Amwins that you and/or your spouse will soon turn age 65 or are already 65 and will be retiring. In either event, you will be eligible to participate in the company-sponsored Retiree Medical Program.

You become Medicare-eligible on the first day of the month in which your 65th birthday falls. You can enroll in USWU's Retiree Medical Program on the first day of the month in which you turn 65. The Retiree Medical Plan picks up where Medicare leaves off and is underwritten by Transamerica Life Insurance Company and serviced by Amwins Group Benefits, LLC.; a division of Amwins Group, Inc.

In addition, a Medicare Part D prescription drug plan underwritten by Retiree RxCare has been made available. By enrolling in the available prescription drug plan, you will be enrolling in a Medicare Part D plan. You do not need to enroll in any other Medicare Part D plans.

How to Enroll

- Review the information in this booklet
- Determine your monthly payment on the "Payment Summary" page
- Complete and sign the appropriate enrollment form(s) for the plans you wish to enroll
    - Transamerica Medical Plan Enrollment Form
    - Retiree RxCare Prescription Drug Plan Enrollment Form
- Include a check made payable to **USWU / Amwins Group Benefits** for the first month's payment.
- Return the above items in the postage-paid return envelope.
  Materials must be received ***10 days prior*** to your effective date to activate your benefits.

If you choose not to participate, complete the enclosed Waiver of Coverage and return in the postage-paid return envelope.

For questions on your enrollment, or to inquire about Medicare Advantage Plans, call Amwins toll-free at 1-1-800-881-0167 Monday- Friday, 8 a.m. to 8 p.m. Or visit: http://uswu.Amwins.com

Retiree Medical Plan Option Summary

Medical Plans underwritten by Transamerica Life Insurance Company		
	Medical Plan Option 1	**Medical Plan Option 2**
Deductibles & Coinsurance / Copays		
	You Pay ǂ	**You Pay ǂ**
Part A Deductible	$0	$0
Part B Deductible *(2026)*	Part B Deductible	$0
Part B Coinsurance Amount	20% up to $500.00	0%
Annual Out of Pocket Maximum	$500.00	$0
Office Visit Copays	$20.00	$0
Medicare (Part A) - Hospital Services - Per Benefit Period (1) In general, Medicare Part A covers hospital care, skilled nursing care (even if received in a nursing home) and some health services.		
	You Pay ǂ	**You Pay ǂ**
First 60 days	$0	$0
61st through 90th day	$0	$0
91st through 150th day (Reserve days)	$0	$0
Additional 365 days	All costs	All costs
SKILLED NURSING FACILITY CARE(1)		
First 20 days	$0	$0
21st through 100th day	$0	$0
101st day and after	All costs	All costs
BLOOD		
First 3 pints	$0	$0
Additional amounts	$0	$0

Retiree Medical Plan Option Summary

	Medical Option 1 ($500.00 Deductible)	Medical Option 2 (Plan F)
Medicare (Part B) - Medical Services - Per Calendar Year In general, Medicare Part B covers services such as lab tests, surgeries, doctor visits and medical supplies considered medically necessary to diagnose or treat a disease or condition.		
	You Pay ǂ	**You Pay ǂ**
First dollars of Medicare-approved amounts [2]	Part B Deductible	$0
Next Medicare-approved amounts	20% up to $500.00	0%[3]
Part B Excess Charges	$0	$0
BLOOD		
First 3 pints	$0	$0
Next dollars of Medicare-approved amounts [2]	Part B Deductible	$0
Next Medicare-approved amounts	20% up to $500.00	0%[3]
CLINICAL LABORATORY SERVICES		
Blood tests for Diagnostic Services	$0	$0
Medicare Parts A & B		
	You Pay ǂ	**You Pay ǂ**
HOME HEALTH CARE		
Medically necessary skilled care services and medical supplies	$0	$0
DURABLE MEDICAL SERVICES		
First dollars of Medicare-approved amounts [2]	Part B Deductible	$0
Next Medicare-approved amounts	20% up to $500.00	0%[3]

Retiree Medical Plan Option Summary

	Medical Option 1 ($500.00 Deductible)	Medical Option 2 (Plan F)
Preventative Services		
	You Pay ǂ	**You Pay ǂ**
Annual Wellness Exam	$0	$0
Other Preventative Services (per Medicare schedule) including cardiovascular screenings, cancer screenings, flu shots, etc.	$0	$0
Other Services – Not Covered by Medicare		
Foreign Travel Emergency [4]		
Foreign Emergency outside of USA	$250.00 Deductible, then 20% up to $50,000.00	$250.00 Deductible, then 20% up to $50,000.00
2026 Monthly Rates Per Member		
Rates are effective from January 1, 2026 to December 31, 2026.		
Age 65+	**$208.88**	**$311.28**

These rates will not be available to residents of FL, ME, NM, OR, RI, VT, AZ and WA. Retirees in these states would be provided with state-specific plans and rates, with details available upon request.
Rates are not available for members under 65 who are eligible for Medicare due to disability.

ǂ The plan options chart represents the amount you pay when the Plans and Medicare are integrated to provide your coverage.

[1] 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.

[2] Once you have been billed the first dollars of Medicare approved amounts for covered services, your Medicare Part B deductible will have been satisfied for the calendar year.

[3] Part B Expenses may also include Office Visit Copays or Emergency Room Visit Copays if applicable. These copays do not apply to the deductible.

[4] Foreign Travel coverage deductible is a separate deductible and does not apply to the Part A or B deductible amounts.

Medicare Prescription Drug Plan Summary

Prescription Drug Plans underwritten by MG Insurance Company		
	Basic Rx Plan	**Enhanced Rx Plan**
Deductible		
	You Pay	**You Pay**
Calendar Year Deductible	$615	$0
Retail Copayments Up to 31-day supply.		
	You Pay	**You Pay**
Tier 1:	25%	$10
Tier 2:	25%	$25
Tier 3:	25%	$50
Tier 4:	25%	25% coinsurance
90 Day Retail & Mail Order Copayments Up to 90-day supply.		
Tier 1:	25%	$20
Tier 2:	25%	$50
Tier 3:	25%	$150
Tier 4:	25%	25% coinsurance
Catastrophic Coverage		
After your yearly out-of-pocket drug costs reach $2,100, you will pay **$0**		
2026 Monthly Rates Per Member		
Rates effective from January 1,2026 to December 31, 2026	**$91.66**	**$255.56**

If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.

2026 MONTHLY PAYMENT SUMMARY

Plan Options	Retiree Only Monthly Costs	Retiree & Spouse* Monthly Costs
Medical Plan Option 1:	**$208.88**	**$417.76**
Medical Plan Option 2:	**$311.28**	**$622.56**

Plan Options	Retiree Only Monthly Costs	Retiree & Spouse* Monthly Costs
Basic Rx Plan	**$91.66**	**$183.32**
Enhanced Rx Plan:	**$255.56**	**$511.12**

**For a spouse to be eligible, they have to join the United Service Workers (USW) Retiree Chapter.*

Rates are effective from January 1, 2026 to December 31, 2026 and are subject to change each year on January 1st.

You can elect both Medical and Prescription Drug coverage, Medical only or Prescription Drug only. Once you have determined your monthly rate, please send a check with your first monthly payment to:

Amwins Group Benefits, LLC.
50 Whitecap Drive
North Kingstown, RI 02852

Please make checks payable to: **USWU / Amwins Group Benefits, LLC.**

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.

RETIREE MEDICAL PLAN ELECTION FORM

United Service Workers Union

Medical plan is underwritten by: Transamerica Life Insurance Company

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):*	

Please Choose Type of Coverage

Effective Date: {effective_date} ***Check Desired Coverage*:**	**Retiree Only**	**Retiree & Spouse**	**Surviving Spouse**
Medical Plan Option:	☐ **Option 1** ☐ **Option 2**	☐ **Option 1** ☐ **Option 2**	☐ **Option 1** ☐ **Option 2**

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.

RETIREE MEDICAL PLAN ELECTION FORM

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.

Release of Information:
By joining this medical 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, LLC 50 Whitecap Drive, North Kingstown, RI 02852
For Customer Service, please call: 1-800-881-0167 Monday through Friday, 8:00 AM to 8:00 PM EST

Retiree RxCare

PRESCRIPTION DRUG PLAN

Enrollment Form for Plans Underwritten by Retiree RxCare
Please provide the following information and sign the last page of this form.

United Service Workers Union **Effective Date: {Effective Date}**

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:	**Spouse or Surviving Spouse:**
☐ Basic Medicare Part D ☐ Enhanced Rx Plan	☐ Basic Medicare Part D ☐ Enhanced Rx Plan

(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 MG 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 MG 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 MG 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 MG 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 MG 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:

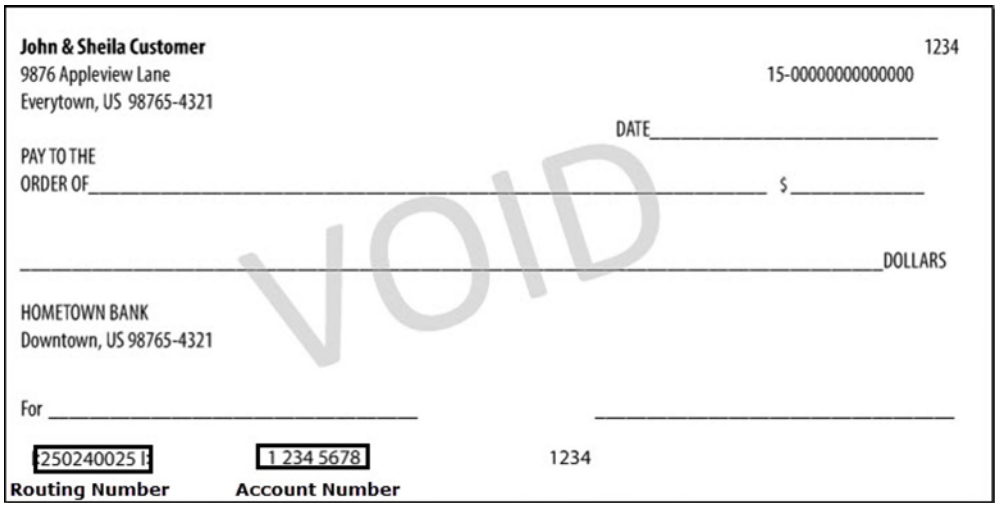
If you are the authorized representative, you must provide the following information:
Name:
Address:
Phone Number:
Relationship to Enrollee:

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

DIRECT PAYMENT AUTHORIZATION FORM

Please read, sign and return with your Enrollment Forms

Name (Last, First, Middle Initial):		
Phone:		
Street Address:		
City:	**State:**	**Zip:**
Type of Account: ☐ **Savings** ☐ **Checking**	**Select Monthly Withdrawal Date:** ☐ **1st** ☐ **8th** ☐ **15th**	
Please fill in the below information:		
Routing Number:	**Account Number:** **Confirm Account Number:**	



Monthly payments are withdrawn on the 1st business day on or after the date you selected above. You will receive a confirmation from Amwins Group Benefits that we have set up your account information to withdraw from your designated bank account. ***Note:*** Your monthly deduction will show as **Amwins** on your bank statement.

I authorize Amwins to withdraw my payment as communicated to me, by invoice or letter, from my checking or savings account. I agree to notify Amwins in writing or by phone, if my account information changes or to stop the direct debit authorization at least 10 days in advance of the scheduled transfer. I understand that the premium to be withdrawn may change, in which case I will be notified in writing at least 10 days before the new premium is withdrawn. To the extent I have enrolled in preauthorized checking, I understand that the addition or removal of a dependent will impact the amount withdrawn, and hereby consent to such change. I understand that Amwins will confirm the new preauthorized amount, but depending on when I submit this request, such confirmation may occur after the amounts are withdrawn from my account. If my account is erroneously charged, my financial institution will immediately credit the same amount to the account up to the 15 days following issuance of the statement or 45 days after posting, which occurs first.

Signature:	Date:

Disclaimer: The benefit information contained in this brochure is subject to change at any time, and the Company 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 at 1-800-881-0167.