

Exhibit

to the

**Production, Maintenance & Parts
Office, Clerical and Engineering
Agreements of November 20, 2023**

between

FCA US LLC
FCA

FIAT CHRYSLER AUTOMOBILES

and the



Exhibit B
**The Life, Disability and Health Care
Benefits Program**

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SHADING REPRESENTS NEW
LANGUAGE IN THE 2023 AGREEMENT

**EXHIBIT B
THE LIFE, DISABILITY
AND HEALTH CARE BENEFITS
PROGRAM**

**Article 1. THE LIFE, DISABILITY AND HEALTH
CARE BENEFIT PROGRAM**

Section 1. Establishment of the Program

Incorporated by reference in the collective bargaining agreements dated November 20, 2023, between FCA US LLC and the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW).

The Life, Disability and Health Care Benefits Program (also known herein as “Program” or “Insurance Program”) consists of the arrangements hereinafter provided for with regard to group life insurance (including optional group life insurance, and dependent group life insurance), group accidental death and dismemberment insurance (including optional group accident insurance), and group sickness and accident, group reinstated sickness and accident, group extended disability benefits and group hospital, surgical, medical, prescription drug, dental, vision and hearing aid benefits, each of which will become effective as provided in Section 2. hereof, for employees as to whom the collective bargaining agreement to which this Program is attached applies. This Insurance Program shall continue so long as that collective bargaining agreement is in full force and effect.

The benefits provided for in this Program shall be in lieu of and in substitution for any and all other plans

providing for insurance, disability benefits, payments or coverage of any kind or nature to employees, retired employees and surviving spouses, for death, sickness, accident, or disability and for hospital, surgical, medical, prescription drug, dental, vision or hearing aid expenses or services of any kind or nature, in which the Company participates other than benefits required by law for occupational death or disability, Federal Social Security benefits and the FCA US LLC Pension Plan dated August 1, 1944, as amended.

The Company shall be under no obligation by reason of this Program except in good faith to endeavor to obtain the coverages referred to herein, and to pay its share of the premiums or subscription charges therefore and to fulfill any obligations it undertakes in the group policies, contracts, or arrangements providing the coverages referred to in this Program.

Any and all references in this Program to an employee or to employees shall include only employees as to whom the collective bargaining agreement to which this Program is attached applies, but shall not include retired employees and the surviving spouses of retired employees for the purposes of Section 3.C.(2) Health Care Benefits of this Article and Article III in its entirety.

Although the benefits as set forth in this Program shall apply to all employees, the benefits for which the following employees are eligible are specified in M-13. Memorandum of Understanding, UAW-Chrysler Group LLC Employees Hired On or After October 29, 2007 Wage & Benefit Agreement, Attachment A, Sections I and III ("MOU"):

- a. Non-skilled classified employees hired or rehired on or after October 29, 2007, and
- b. Skilled trade classified employees hired or rehired on or after October 12, 2011, and
- c. Dundee Engine Plant employees hired or rehired on or after October 12, 2011, and
- d. Salaried bargaining unit employees hired or rehired on or after April 15, 2010, and
- e. All employees whose employment becomes subject to the Engineering, Office and Clerical Agreement on or after January 1, 2017, and who, immediately prior to that employment, were:
 1. Non-skilled classified employees hired or rehired on or after October 29, 2007, or
 2. Skilled trade classified employees hired or rehired on or after October 12, 2011, or
 3. Dundee Engine Plant employees hired or rehired on or after October 12, 2011, or
 4. Non-represented employees, regardless of date of hire.

The benefits described in this Program shall apply to these employees except to the extent provided for under the MOU.

Section 2. Program Effective Date

Any reference in this Program to the Effective Date of this Program or to the Effective Date shall be construed to mean November 20, 2023 and the provisions of this Program with regard to group life insurance, group accidental death and dismemberment insurance, group sickness and

accident insurance, group reinstated sickness and accident insurance and group extended disability insurance shall, except as otherwise expressly provided herein, become effective on the Effective Date; and the provisions of this Program with regard to group hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverage shall, except as expressly otherwise provided herein, become effective for each locality providing such coverage on November 20, 2023 or such date thereafter as may be practicable for the locality. Until the applicable respective provisions of this Program become effective in accordance with the above sentence and except as otherwise expressly provided herein, the applicable provisions of the Insurance Program incorporated by reference in the collective bargaining agreements dated December 16, 2019 between the Company and the UAW shall continue in effect, but no change in benefits thereunder shall result from any adjustments in pay rates provided for in the collective bargaining agreement to which this Program is attached, prior to November 20, 2023. Notwithstanding the provisions in Article III, Section 1., all changes in coverage resulting from a change made in this Program from the Program in effect immediately prior to the Effective Date shall become effective in accordance with the first sentence of this Section, subject to Section 3. D. (2) below.

Section 3. A. Group Insurance

A. Group Insurance

(1) Insurance Coverage Arrangements

The Company now has in effect group life insurance, (including optional group life insurance and dependent group life insurance), group accidental

death and dismemberment insurance policies, group sickness and accident, group reinstated sickness and accident and group extended disability benefits.

The Company, during the period of this Program, will renew said group insurance policies or continue them in effect, with appropriate riders, or will (a) obtain new insurance policies on terms as similar to those of the existing group insurance policies as the Company is reasonably able to obtain, or (b) enter into administrative services contract arrangement or such other arrangement as may be subsequently agreed upon by the Company and the Union. In addition, the Company will obtain optional group accident insurance coverage with the provisions hereinafter set forth in Section 5. Insurance company or insurance companies or administrators of administrative services only arrangements are referred to as the Insurance Company. Insurance policies, together with administrative services only contracts and any rider or riders incorporated therein, shall determine the rights and obligations of all persons with respect to group life insurance (including optional group life insurance and dependent group life insurance), group accidental death and dismemberment insurance (including optional group accident insurance), group sickness and accident, group reinstated sickness and accident and group extended disability benefits under this Program.

Except as otherwise specified herein, the Company may provide the benefits under the Program through insured arrangements, uninsured arrangements or combinations thereof. As to any group insurance policy, if the Insurance Company shall be unable to change, be unable to issue, or refuse to change or issue, the group insurance policy so as to

contain any one or more of the provisions referred to in this Program, no employee, retired employee or surviving spouse shall have any right or benefit that he would have had under the group insurance policy if it had contained such provision or provisions. As to any other contract or arrangement, if the underwriter shall be unable to change, be unable to issue or provide, or refuse to change, issue, or provide, the contract or arrangement so as to contain or include any one or more of the provisions referred to in this Program, no employee, retired employee or surviving spouse shall have any right or benefit that he would have had under the contract or arrangement if it had contained or included such provision or provisions. If, for any reason not due to the fault of the Company, the Insurance Company or any other underwriter shall terminate or refuse to renew the group insurance policies, contracts, or arrangements, or any of them, the Company shall endeavor to obtain new group insurance policies, contracts, or arrangements, or any of them, providing coverage or coverages as similar to those provided by the terminated or not renewed policies, contracts, or arrangements, as the Company is reasonably able to obtain.

For purposes of group sickness and accident insurance, group reinstated sickness and accident insurance and group extended disability insurance, references in this Program to “group insurance”, “insurance”, “insurance arrangements”, “insurance contracts”, “insurance coverage”, “coverage”, “insurance policies”, “insured” or “premiums” may include the Company’s provision of coverage through insurance or an administrative services only arrangement or by making actuarially determined cash contributions to be held in a trust of the type described in Section 501(c)(9) of the Internal Revenue Code,

or such other arrangement as may be subsequently agreed upon by the Company and the Union.

In those instances, in which an Insurance Company administers a program for the Company, the Insurance Company shall be acting as an agent of the Company.

B. Financing

During the term of this Program, the Company will pay the premiums required, including any future increases of premiums, for the group insurance referred to in Article II. and the hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverages referred to in Article III., except for such contributions or payments by employees, retired employees and surviving spouses as are required under the Program. The Company shall receive and retain any dividends paid or credits, refunds, or reimbursements, by whatever name called, made in respect of the group insurance, except contributory plans, and the hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverages referred to Articles II and III respectively.

(1) Company Contribution

The Company will, except as provided in Article III., contribute for each employee covered hereunder who is actively on the payroll of the Company at any time during a month (an employee is not regarded as actively on the payroll during the period he is on leave of absence or laid off), the entire group premium or subscription charges for the following month's coverage hereunder of such employee for that month; provided, however, that the Company's contributions

toward the alternative plan will not exceed the rates for the Standard Care Network option unless the Company at its option waives this limitation in whole or in part; and provided further, that for an employee on strike (an employee is not regarded as actively on the payroll during the period he is on strike), the Company's contribution toward the group premium or subscription charges is limited to the end of the month in which the strike commenced.

(2) Employee Contribution

When contributions or payments by employees, retired employees or surviving spouses are required, they shall pay their contributions to the Company, or its designated administrator, in cash on or before the 10th day of the month for which coverage is to be provided or, if suitable arrangements can be made, directly to the carrier on or before the due date.

C. Local, State and Federal Laws

(1) Disability Benefits

Where an employee is entitled to disability benefits under a local, state or federal law, whether the benefits are paid directly by the local, state or federal agency, by a third party through an insurance policy maintained by the Company to comply with such law or by the Company or the Company's Claim Administrator pursuant to an approved self-insurance arrangement (as approved by the applicable local, state or federal agency), the Company's obligation for sickness and accident, reinstated sickness and accident and extended disability benefits is limited to the amount by which the employee's benefit under the provisions of Article II exceed the local, state or federal

benefit. Receipt of disability benefits under a local, state or federal law does not affect an employee's eligibility for benefits under Article II, Sections 6, 7 and 8; however, an offset for such benefit will be applied to an employee's sickness and accident, reinstated sickness and accident or extended disability claim, as applicable, for the same period for which benefits have been paid pursuant to such local, state or federal law.

(2) Health Care Benefits

In the event that any federal health security act or any other federal or state law, other than a workers' compensation or occupational disease law, is hereafter amended or enacted requiring that hospitalization, surgical, medical, prescription drug, dental, vision or hearing aid coverage, or any combination thereof, be afforded for employees, or surviving spouses of certain deceased employees not eligible to retire or prescribing hospitalization, surgical, medical, prescription drug, dental, vision or hearing aid benefits, or any combination thereof, for employees or surviving spouses of certain deceased employees not eligible to retire, and if such law is not pre-empted by ERISA, Article III, Section 1. of this Program shall not be applicable to employees or surviving spouses of certain deceased employees not eligible to retire subject to that law. In that event, compliance with such law shall be without prejudice to the Company's rights and privileges under ERISA and shall be deemed compliance with the provisions of Article I. of this Program, with respect to employees or surviving spouses of certain deceased employees not eligible to retire coming within that law. Notwithstanding the foregoing, and without prejudice to its rights and privileges under ERISA, if as a result of such laws, the level of benefits provided

for any group of employees, surviving spouses of certain deceased employees not eligible to retire or their eligible dependents is generally lower than the corresponding level of benefits under Article III. of this Program, the Company shall upon mutual agreement with the Union make available to such employees, surviving spouses or their eligible dependents hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverage or supplemental coverage so that the total benefits provided will be as nearly equal as practicable to those referred to in Article III. of this Program with such contributions by employees, or surviving spouses of certain deceased employees not eligible to retire as are mutually determined to be consistent with the contributions established in such Article III. provided that approval of:

(a) such group insurance coverage or supplemental insurance coverage as compliance by the Company with or as permitted by such law, and

(b) the contents of the insurance policy and contract form of such group coverage or supplemental coverage, is obtained and continuously maintained from the proper governmental authorities in the jurisdiction involved, and, to the extent required, from the Michigan Insurance Department.

Subject to the provisions of the Program and to the extent required by applicable law:

(a) payments or contributions for coverages made with respect to an enrollee will be made in accordance with any assignment of rights made by or on behalf of such enrollee as required by a State plan for medical assistance approved under the applicable provisions of the Federal Social Security Act;

(b) when enrolling an individual or determining or making payment for coverages with respect to such individual, the Program will not take into account the fact that such individual is eligible for or is provided assistance under a State plan for medical assistance approved under the applicable provisions of the Federal Social Security Act; and

(c) in any case where the Program is legally liable for payment for items constituting medical assistance which have been paid for by a State plan approved under the applicable provisions of the Federal Social Security Act, the Program will make payment for such medical assistance in accordance with the applicable provisions of OBRA 93.

D. Effective Date of Insurance

(1) New Hire

(iii) A newly hired employee shall become eligible for coverage under this Program after the Effective Date described herein, (a) a newly hired employee shall become eligible for group life insurance and accidental death and dismemberment insurance on the first day in which employment commences, (b) a newly hired employee shall not be eligible for sickness and accident insurance benefits until the first day of the sixth calendar month next following the month in which employment commences; (c) a newly hired or rehired employee shall be eligible for hospital, surgical, medical, prescription drug, dental, hearing aid and vision coverage as of the 90th day following date of hire or rehire (“Initial Eligibility Date”);

(2) Away From Work On Effective Date

If an employee is both disabled (i.e., ill or injured) and away from work, or is on a layoff or leave of absence, on the date any, sickness and accident, reinstated sickness and accident or extended disability coverage under this Program (except the coverages referred to in Article I, E. (2), and Article II., Section 1 B. and D.) would otherwise become effective for him (including changes in coverage which would otherwise become effective on the Effective Date of this Program described in Article I), the effective date of such coverage will be deferred until the date he returns to active work. A leave of absence existing on the Effective Date of this Program for an employee working with a Local Union or the International Union will not operate to defer the effective date of any coverage for such employee under this Program.

All employees who are covered or receiving or entitled to benefits, or having rights under the coverages in effect prior to the Effective Date of this Program who are not eligible to become covered thereby on the Effective Date of this Program, shall retain such status, benefits, or rights in accordance with the conditions, provisions, and limitations of such coverages so long as they remain ineligible to become covered by this Program.

(3) Returning from a Military Leave

An employee upon reporting for work from military leave of absence in accordance with the terms of such leave shall be immediately eligible, whether he is reinstated or immediately placed on layoff, at no cost to the employee, for group life and accidental death and dismemberment insurance coverage and for hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverage for the remainder of

Unemployment Benefit Plan (SUB Plan), the Company's contribution for insurance coverages described in Article II and III, except the contributory plans, will be continued so that the employee's insurance will be kept in force until the end of the month following the month in which the layoff began. For each full calendar month of layoff thereafter, the insurance, except sickness & accident, extended disability and dental coverages, will be continued without cost to the employee for the number of months of coverage, up to a maximum of twenty-four for which the employee would be eligible on the basis of his years of seniority on the date layoff begins, in accordance with the following table:

Year(s) of Seniority on Date Layoff Begins	Maximum Number of Months for which Insurance will be Continued Without Cost to Employee
Less than 1	0
1 but less than 2	3
2 but less than 3	5
3 but less than 4	7
4 but less than 5	9
5 but less than 10	12
10 and over	24

In the event of an indefinite layoff, healthcare coverage, except for dental, will continue for a maximum of 24 months, provided the employee is eligible for SUB or Transition Assistance.

Following the expiration of the Maximum Number of Months for which insurance will be continued without cost to the employee, the Company will make arrangements so that the employee may continue

insurance as follows:

(i) Life, Survivor Income, Accidental Death and Dismemberment

- by making monthly contributions at the rate of 50 cents per \$1,000 of group life insurance in force, up to a maximum period of twelve additional months.

(ii) Hospital, Surgical, Medical, Drug, Vision, Hearing Aid (Not Dental)

- Coverage will be continued through an automatic COBRA enrollment. The Company will subsidize the full cost of the COBRA coverage until the end of the month following the month in which the layoff began plus the number of months in the table above. Thereafter the COBRA can be continued at full COBRA cost paid by the employee for the remaining months of layoff up to a maximum of thirty-six (36) months.

(iii) Dental

- Coverage will be continued through an automatic COBRA enrollment. The Company will subsidize the full cost of the COBRA coverage until the end of the month following the month in which the layoff began. Thereafter the COBRA can be continued at full COBRA cost paid by the employee for the remaining months of layoff up to a maximum of thirty-six (36) months.

If an employee reaches his 65th birthday while his group life insurance is being continued under this

Section, his insurance shall thereafter be reduced as provided in Article II, Section 1. B.

(b) Layoff Other Than (a) Above

For a layoff other than of the type covered in (a) above, the Company's contribution will continue until the end of the month following the month in which the layoff begins. Thereafter, the Company will make arrangements so that the employee may continue insurance as follows:

(i) Life, Survivor Income, Accidental Death and Dismemberment

- by making monthly contributions at the rate of 50 cents per \$1,000 of group life insurance in force, up to a maximum period of twelve additional months.

(ii) Hospital, Surgical, Medical, Drug, Vision, Hearing Aid (Not Dental)

- The Company will subsidize the full cost of the COBRA coverage until the end of the month following the month in which the layoff began. Thereafter the COBRA can be continued at the full COBRA cost paid by the employee for the remaining months of layoff up to a maximum of eighteen (18) months.

(iii) Dental

- Coverage will be continued through an automatic COBRA enrollment. The Company will subsidize the full cost of the COBRA coverage until the end of the month in which the layoff began. Thereafter the COBRA can be continued

at full COBRA cost paid by the employee for the remaining months of layoff up to a maximum of eighteen (18) months.

The insurance as described in (b) (i) above of an employee on layoff who becomes totally and continuously disabled and becomes eligible for reinstated sickness and accident benefits under the provisions of Article II, Section 7 shall be continued while the employee remains totally and continuously disabled, but not to exceed the period for which the employee is eligible to receive extended disability benefits, with no employee contributions; and with the further provision that in each instance if group life insurance is in force when the employee reaches his 65th birthday, it shall thereafter be reduced as provided in Article II, Section 1.

The insurance as described in (b) (i) above of an employee who is placed on leave of absence because he is unable to return to work when recalled from a layoff due to his having become totally disabled while on the layoff, shall be continued or reinstated, and such insurance shall be continued for the duration of such leave of absence or a period equal to his seniority on the date of disability, whichever is less, with no employee contributions.

The insurance as described in (2) (d) below will apply to employees separated on a disciplinary layoff.

(2) Leave of Absence

For leave of absence, the Company's contributions for insurance coverage as described in Article II, except as described in (c) below, and Article III, except dental, will be continued in force until the end

of the month following the month in which the leave of absence began. Dental coverage continues until the end of the month in which the leave of absence begins except as provided in (c) below. Thereafter, insurance coverage will be continued as follows:

(a) Personal Leave

Insurance as described in this subsection may continue for the period described in (i), (ii) and (iii) below. This provision includes an employee who is granted a leave of absence because of a clinically anticipated disability based on the natural course of the employee's diagnosed condition. If however, such employee continues insurance as described below and subsequently presents medical certification from his/her personal physician, satisfactory to the Company, that the employee is totally disabled, the Company will contribute for insurance coverage for such employee from the date certification is presented on the same basis as set forth in (c) below.

(i) Life, Survivor Income, Accidental Death and Dismemberment

- Coverage will be continued in force until the end of the month following the month in which the leave of absence began and then by making monthly contributions at the rate of 50 cents per month per \$1,000 of group life insurance in force, up to a maximum period of twelve additional months.

(ii) Hospital, Surgical, Medical, Drug Vision, Hearing Aid (not Dental)

- Coverage will be continued through an automatic COBRA enrollment. The

Company will subsidize the full cost of the COBRA coverage until the end of the month following the month in which the leave of absence began. Thereafter the COBRA can be continued at full COBRA cost paid by the employee for the remaining months of leave up to a maximum of eighteen (18) months.

(iii) Dental

- Coverage will be continued through an automatic COBRA enrollment. The Company will subsidize the full cost of the COBRA coverage until the end of the month in which the leave of absence began. Thereafter the COBRA can be continued at full COBRA cost paid by the employee for the remaining months of leave up to a maximum of eighteen (18) months.

(b) Union Leave

Insurance as described in (i), (ii) and (iii) below for Local Union leave and (b) (i) International Union leave requested by the employee's Local Union or International Union to permit him to work for the Local Union or the International Union may be continued until the date such leave or any extension thereof ceases to be operative.

(i) Life, Survivor Income, Accidental Death and Dismemberment

- by making monthly contributions at the rate of 60 cents per \$1,000 of group life insurance in force.

(ii) Sickness and Accident

- by making monthly contributions of \$5.00.

(iii) Hospital, Surgical, Medical, Drug, Dental, Vision, Hearing Aid

- by making monthly contributions as a member of the group without contribution from the Company.

(c) Disability Leave

Insurance coverage as described in Article II and III, except the contributory plans, for an employee who is on an approved leave of absence because he has become totally disabled while actively at work or because he has physical limitations which require him to be temporarily separated as a "PQX Disability", shall be continued for the duration of such leave of absence or a period equal to his seniority, whichever is less, provided, however, that such employee attain coverage under Medicare Part B when first eligible to do so, with no employee contributions.

An employee who last worked prior to May 16, 1988, whose group coverage has been continued in accordance with the preceding paragraph and who qualifies for group life insurance permanent total disability benefits may further continue his hospital, surgical, medical, prescription drug, vision and hearing aid (but not dental) coverage without contribution from the Company for a period equal to his seniority on his last day worked, upon submission of such periodic proof of the continuance of such disability as the Company may reasonably require, subject to the approval of the local plans.

If any employee on disability leave of absence is determined to be "Able" in accordance with the Chrysler Disability Benefits – Disability Evaluation Program (DEP) Exam, and does not return to work following such determination, health care coverages will be discontinued on the first day of the month following the month in which such determination is made and not reinstated until the employee returns to work.

(d) Leave of Absence For Disciplinary Reasons

The Sickness and Accident insurance of an employee who is placed on leave of absence for disciplinary reasons shall cease effective on the first day of such leave of absence; provided, however, that if the employee becomes disabled while on the disciplinary leave of absence, sickness and accident benefits shall not be paid during the period of such disciplinary leave. If the employee remains disabled beyond the period of the leave of absence, his disability shall be deemed to have commenced effective with the first normal workday following the termination of such leave of absence and sickness and accident benefits shall be payable following the appropriate waiting period if he is otherwise eligible to receive such benefits. Effective June 1, 1998, employees temporarily separated on a disciplinary leave of absence or disciplinary layoff under the absentee procedure shall have dental coverage continued until the end of the month following the month in which the disciplinary leave or disciplinary layoff begins.

(3) Loss of Seniority

(a) Quit

For an employee who loses his seniority because of a quit, insurance as described in Article II and dental coverage will cease as of the date the loss of seniority occurs. With respect to the coverage described in Article III, except dental, the Company's contributions will cease as of the end of the month in which loss of seniority occurs.

(b) Discharge

In the case of an employee who loses his seniority through discharge, absence from work without notifying the plant as required by the Collective Bargaining Agreement, or failure to return to work when called, the employee's insurance and the Company's contributions for such insurance will cease as of:

(i) Coverage as described in Article II – the date the loss of seniority occurs;

provided, however, if such an employee is seeking to have his seniority reinstated through the grievance procedure, the limit for continuation of his insurance shall be the period his grievance is pending, with the Company contributing for such continuing coverage until the end of the month in which the loss of seniority occurs and the employee thereafter contributing for such continuing coverage at the rate of 50 cents per month per \$1,000 of group life insurance in force; and provided further, however, that if the employee is reinstated the Company will reimburse him for all the contributions in respect to coverage which the Company would have made if the employee had remained on the active payroll.

(ii) Coverage as described in Article III - the end of the month in which the loss of seniority occurs;

provided, however, that if such an employee is seeking to have his seniority reinstated through the grievance procedure, the Company's contributions will continue so that if such loss of seniority occurs after October 29, 1979, coverage will be provided until the end of the month following the month in which the loss of seniority occurs; and thereafter the Company will arrange for such an employee to continue as a member of the group, but without contribution from the Company, his coverage during the period his grievance is pending; and provided further, however, that if the employee is reinstated, the Company will reimburse him for all the contributions in respect to such coverage, under this paragraph which the Company would have made if the employee had remained on the active payroll.

(c) Application For Separation Payment

If an employee loses his seniority by reason of applying for Separation Payment under Article IV, Section (1)(f) of the SUB Plan, the employee's insurance and the Company's contributions for such insurance coverage will continue for the number of months of coverage, determined in accordance with item E. (1) above at the time the employee was laid off, remaining as of the date of such application as if the employee were still on layoff.

F. Amount of Insurance

Amounts of group life, group accidental death and dismemberment, group sickness and accident, group reinstated sickness and accident and group extended disability insurance shall be determined in

accordance with the Schedule of Benefits in Section 9. hereof, except that an employee who returns from an occupational disability absence and because of continuing physical limitation connected with such occupational disability is placed on a job paying a lower rate than the job he held immediately prior to his disability absence, will have amounts of group life, group accidental death and dismemberment, group sickness and accident, group reinstated sickness and accident and group extended disability insurance determined in accordance with the higher rate of his former job, as determined by the Schedule of Benefits for as long as he receives payments under any applicable workers' compensation law in reimbursement for the loss in pay occasioned by such physical limitation.

Each increase or decrease in the amount of an employee's group life, group accidental death and dismemberment, group sickness and accident, group reinstated sickness and accident or group extended disability insurance due to an increase or decrease in pay rate shall become effective automatically on the first day of the month coinciding with or next following the date the increase or decrease becomes effective; provided, however, that if an employee is both disabled (i.e., ill or injured) and away from work, or is on a layoff or leave of absence, on the date his insurance would otherwise be increased or decreased, the effective date of the increase or decrease in insurance shall be deferred until his return to active work. For insurance purposes, any retroactive change in an employee's rate of pay shall be deemed to become effective on the date of the determination of the change in the rate of pay. Irrespective of the foregoing, if an employee's pay rate on the last day worked preceding the date of illness or injury or the date of his death would, under

the Schedule of Benefits in Section 9., entitle the employee or beneficiary to a higher amount of sickness and accident insurance benefits, reinstated sickness and accident insurance benefits, extended disability insurance benefits, group life insurance or accidental death and dismemberment insurance, payment of benefits shall be on the basis of the higher amount.

G. Overpayment

If it is determined that any benefit or benefits paid to an employee under the group insurance referred to herein, should not have been paid or should have been paid in a lesser amount, written notice thereof shall be given to such employee and they shall repay the amount of the overpayment to the Insurance Company or Claim Administrator, provided, however, that no repayment shall be required if notice has not been given within 6 months from the date the Insurance Company or Claim Administrator determines an overpayment exists. If the employee fails to repay such amount of overpayment promptly, the Insurance Company or Claim Administrator shall arrange to recover the amount of the overpayment as follows:

a) by making an appropriate deduction or deductions from any future benefit payment or payments payable to the employee under the group insurance referred to in Section 1;

b) by requesting the Company make or arrange for an appropriate deduction or deductions from any monies then payable, or which may become payable, by the Company, or on the Company's behalf, or otherwise, to the employee in the form of wages or benefits.

The Company shall have the right to make or arrange to have made deductions for recovering such overpayments from any such present or future wages or benefits, excluding Profit Sharing payments and any other bonus-related payments paid by the Company pursuant to the provisions of the Collective Bargaining Agreement, which are or become payable to such employee. The Company intends that these deductions will be made in a reasonable manner so as not to cause employees undue hardship.

An overpayment recovery deduction pursuant to this section shall comply with all limits imposed by federal, state and local laws related to payroll deductions.

At the direction of the Company, the Insurance Company or Claim Administrator shall make an appropriate deduction or deductions from any future benefit payment or payments payable to the employee under the group insurance for the purpose of recovering overpayments made to an employee under any FCA US, LLC employee benefit plan. Amounts so deducted shall be remitted by the Insurance Company or Claim Administrator to the applicable benefit plan. The Insurance Company or Claim Administrator, by such remittance, shall be relieved of any further liability with respect to such payments.

If any benefits listed in Article II, Section 6., D., E. and Section 8. B. are awarded retroactively, they shall be treated as having been received by the employee during the entire time period for which such benefits were payable and any overpayment of any Program benefits shall be calculated accordingly.

H. Procedure for Review of Denied Claims

To afford employees a means by which they can seek review and possible reconsideration of a denied life, disability and health care claims, internal procedures of the Company and the Insurance Company will provide a procedure as indicated below. The term “claims processor” in Section H.3 means an entity contracting with the Company, or subcontracting with an entity contracting with the Company, to process claims for covered benefits under the program.

(1) Life

If a claim for life insurance, survivor income benefit insurance, or accidental death and dismemberment insurance is denied in whole or in part, a notice will be sent explaining the reason for the denial. If there are any questions concerning the denial, inquiry should be made within 60 days from the date the claim was denied to the Insurance Company. The letter should state the reason the claim should not have been denied and should include a copy of the notice and any additional documents, records, information, or comments which have a bearing on the claim. Written notice of the decision will be sent within 60 days after receipt of the appeal.

(2) Disability

(a) The formal notification letter from the Claim Administrator by which the employee is advised that their claim is denied will inform the employee that they have any questions regarding the denial they may be referred to the Claim Administrator.

(b) Upon request, the Claim Administrator will advise what if anything the employee can do to support their claim for payment of benefits. The employee, by themselves or through their UAW Benefit Representative, may submit supporting documentation to the Claim Administrator, who will perform a review of extenuating circumstances or an independent review, as outlined in Article II, Section 6. At any time, without pursuing an extenuating circumstances or independent review, an employee may request that their UAW Benefit Representative initiate an appeal, as outlined in (d) below.

(c) The Claim Administrator will notify the employee of their decision regarding the payment of benefits upon completion of their review of extenuating circumstances or independent review.

(d) If after the extenuating circumstances review or independent review, the employee's claim for benefits remains denied, or if the employee opts to initiate an appeal as noted in (b) above, the employee's UAW Benefit Representative may request an appeal on behalf of the employee. The appeal will be referred to the Company and the International Union for disposition.

(e) Upon receipt of the request for appeal as provided in (d) above, the Company and the International Union will review the claim on appeal. Either party may request that an Independent Medical Exam (IME) be undertaken to facilitate the appeal decision. The decision of the Company and the International Union on appeal will be final and binding on all parties.

The provisions noted in (a) through (e) above apply to benefits denied under Sickness and Accident (Article II, Section 6) and Reinstated Sickness and Accident (Article II, Section 7). Upon request by the employee to the Claim Administrator, benefits denied under Extended Disability (Article II, Section 8) are subject to a review pursuant to the provisions of ERISA.

(3) Health Care

(a) Initial Determination

If an application for benefits is denied in whole or in part, written notice will be made to the enrollee as soon as practicable but generally no later than 45 days (unless special circumstances require an extension of time) after the request is received. This notice will include:

- (i) The specific reason or reasons for the denial
- (ii) Specific reference to plan provisions on which the denial is based
- (iii) A description of any additional material or information necessary for the enrollee to perfect the claim and an explanation of why such material or information is necessary
- (iv) A description of the Plan's review procedures and applicable time limits

(b) Appeal of the Initial Determination

If an enrollee wishes to appeal an adverse claim determination, the enrollee has at least 180 days following receipt of notification of an adverse benefit determination to submit a written appeal of the determination. Following the instructions provided

on the Explanation of Benefit (EOB) form received from the Claims Processor, the enrollee must send the written appeal to the address of the appropriate Claims Processor. If the enrollee authorizes a local union benefit representative to act on their behalf, the union representative may file the appeal for the enrollee. In the case of a claim involving urgent care, when the services in question require preauthorization, the enrollee or authorized union representative may initiate the appeal by a telephone call to the appropriate Claims Processor.

Claims for eligibility should be sent to the third party eligibility administrator. The request for review should be submitted in writing to the Claims Processor (or third party eligibility administrator, as appropriate) and must include at least the following information:

- (i) Name of employee
- (ii) Name of plan
- (iii) Reference to the initial decision
- (iv) An explanation why the enrollee is appealing the initial determination

The Claims Processor (or third party eligibility administrator, if the issue is eligibility) will review the appeal and provide a decision on the appeal within the applicable time period. Claims Processors may use a two-step process for such appeals. If the two-step process is applicable, the enrollee should follow the instructions on the first appeal response received to elevate the appeal to the second step. In states that require HMOs to have an external review process, the HMO's appeal process may have three steps.

If the appeal is denied in whole or in part, the enrollee may bring a civil action under Section 502(a)

of the Employee Retirement Income Security Act of 1974 or the enrollee may follow the voluntary appeal process set forth in Section (c) below. No action at law or in equity may be brought to recover until the appeal rights in Sections (a) and (b) have been exercised and the plan benefits requested in such appeal have been denied in whole or in part.

(c) Voluntary Appeal Process

If the enrollee disagrees with the decision of the Claims Processor, the enrollee may file a voluntary appeal. The enrollee may also request the local union benefit representative to review the claim with the International Union and the Company for further consideration.

The enrollee's decision to submit an adverse claim determination for review under the voluntary procedure will not have an effect on rights to any other benefits under the Plan.

The enrollee can elect to submit an adverse claim determination for review under the voluntary procedure only after exhaustion of the appeal process described in (b).

Any statute of limitations or other defense based on timeliness is tolled during the time that the voluntary review is pending. The Plan waives any right to assert that enrollee has failed to exhaust administrative remedies because the enrollee did not elect to submit a claim determination for review under the voluntary process.

The Plan will not impose fees or cost for this review.

(d) PPACA External Review Process

Pursuant to the Patient Protection and Affordable Care Act (PPACA), effective January 1, 2012, enrollees shall have the additional option of external review. To the extent any or all of the external review mandates are repealed or otherwise eliminated under PPACA, the external review will likewise be eliminated and the terms of the Program will revert back to those in place immediately prior to the adoption of the eliminated covered service(s). If the external review is modified the Company reserves the right to make the required changes.

I. Data Reports

Upon request by the Union, the Company will furnish and/or request the Insurance Company to furnish relevant data regarding sickness and accident benefits, reinstated sickness and accident benefits, extended disability benefits, life insurance, survivor income benefit, accidental death and dismemberment insurance, optional and dependent group life insurance and optional group accident insurance.

Relevant data includes but is not limited to:

- (1) For sickness and accident, reinstated sickness and accident and extended disability benefits:
 - (a) Number of insured employees
 - (b) Number of new claims
 - (c) Number of closed claims
 - (d) Average paid per week or month
 - (e) Average amount of offsets
 - (f) Total amount of benefits paid

- (g) Number of denied claims by denial category
 - (h) Average claim duration (for closed claims)
 - (i) Number of injury claims and number of illness claims (for sickness and accident)
- (2) For life and accidental death and dismemberment insurance:
- (a) By benefit level, number of insured employees
 - (b) Number of claims
 - (c) Number of deaths and total amount of benefits paid
- (3) For survivor income benefit:
- (a) Number of claims for both transition and bridge benefits
 - (b) Total amount of benefits paid
- (4) For optional and dependent life insurance:
- (a) Number of participants, by coverage type (employee, spouse, child) and by level of coverage
 - (b) Number of claims by coverage type
 - (c) Total amount of benefits paid
- (5) For optional group accident:
- (a) Number of participants by coverage type (employee, family) and by level of coverage
 - (b) Number of claims
 - (c) Total amount of benefits paid
- (6) Any other data element which relates to employee coverage, employee participation, number of claims, total amount of benefits

paid or any other information upon which the Company and the Union agree.

J. Life and Disability Subrogation

If an employee's death or disability for which any benefits are paid under a Group Life and Disability Plan is the result of circumstances or an event which creates a legal liability in another person or entity and the employee (or his/her dependents or personal representative) seeks to recover compensatory or economic damages through legal or other action against that person or entity, the Company or Insurer may take legal or other action to join the action initiated by the employee to recover the cost of benefits paid by the respective Plan. If compensatory or economic losses (but not punitive losses or sums allocated to compensate for pain and/or suffering) are recovered by an employee or his/her estate in a personal injury action, such payments shall be offset from the benefits paid or payable from the respective Plan. If the employee's recovery creates an overpayment of the benefits paid by the respective Plan and the Company or Insurer is not reimbursed by the employee from such recovery, the Insurer may initiate its normal overpayment recovery procedures to recoup the overpayment from the employee. When recovery is made by the Company or claims processor under this provision, a share of the expense of the recovery, including attorney fees, will be paid by the respective Plan. The expenses to be paid will be those ordered by the court or, in absence of a court order, in the same proportion as the amount recovered by the Plan of the total recovered as a result of the personal injury action.

If the employee (or his/her dependent or personal representative) does not commence an action to enforce the liability of the other person or entity within eighteen (18) months after the occurrence of the death or disability, the Company or Insurer may, in its own name and within the period of time for commencement of actions prescribed by statute, initiate action to enforce the right of recovery against the liable person or entity.

The amount to be subrogated under this provision will not exceed the total cost of the benefits paid by the respective Plan. Subrogation will not be pursued if it will result in an employee's gross recovery being less than the total of the benefits paid or payable under the respective Plan.

This subrogation provision will not impede any action initiated by the Company to recover medical benefits paid under the HSMDDV Plan according to the subrogation provisions of that Plan.

Section 4. Joint Insurance Committee

A committee, referred to as the Joint Insurance Committee, composed of members designated by the Union and members designated by the Company (of equal number), has been established to study and evaluate the coverages described under Articles II. and III. of this Program. The committee will make recommendations and take such action as necessary for the purpose of optimizing coverage and service for the employees covered by the various hospital, surgical, medical, prescription drug, dental, vision, hearing aid plans and group insurance and improving the quality and cost effectiveness of such coverages. In the performance of its duties, this committee

shall consult and advise with representatives of organizations providing the health benefits and services and keep the parties to the contract informed with respect to the problems which arise in the operation of the program. The committee shall also undertake the applicable functions that are set forth in Articles II and III, and in Letter C-12.

Section 6. Waiver of Bargaining

Unless expressly provided in this Program, neither party shall request, demand, or propose any change in this Program or any modification thereof or supplement thereto, or with respect to any plan or arrangement contemplating payment of benefits of the kinds provided for by this Program, or with respect to contributions concerning such plan or arrangement, nor shall a change in or addition to this Program be an object of or a reason for any strike or lockout or other exercise of economic force or threat thereof by the Union or Company

Section 7. Program Administrator and Named Fiduciary

A. Administrator and Fiduciary

The Company is the Program Administrator and Named Fiduciary. The Board of Directors of the Company shall have the authority on behalf of the Company to approve Program amendments, except that the Vice President - Employee Relations is designated to approve program additions, deletions and modifications on behalf of the Company to the extent deemed necessary or appropriate under ERISA.

Except as otherwise provided in this Section or in the Program, the Vice President - Employee Relations is designated to carry out the Company's responsibilities with respect to the Program. The Vice President - Employee Relations may designate other persons to carry out specific responsibilities on behalf of the Company.

In the event of a change in a designated officer's title, the officer or officers with functional responsibility for the Program shall have the authority to the extent described in this subsection.

Any Company director, officer or employee who shall have been expressly designated pursuant to the Program to carry out specific Company responsibilities shall be acting on behalf of the Company. Any person or group of persons may serve in more than one capacity with respect to the Program and may employ one or more persons to render advice with regard to any responsibility such director, officer or employee has under the Program.

B. Administrator Authority

The Program Administrator shall have full power and authority to administer the Life, Disability and Health Care Benefits Program and to interpret its provisions, including, but not limited to, discretionary authority to determine eligibility for and entitlement to Program benefits, subject only to an arbitrary and capricious standard of review

Article II. GROUP LIFE AND DISABILITY INSURANCE

Section 1. Group Life Insurance

The group life insurance policies referred to in Article I. hereof or any group life insurance policy or policies issued in lieu thereof shall, for the period of this Program, provide coverage for employees and retirees as indicated below:

A. Employees and Retirees Under Age 65

Employees and retirees prior to age 65 will have group life insurance in amounts determined from the Schedule of Benefits set forth in Article II., Section 9.

B. Employees and Retirees Age 65 and Over

Employees age 65 and over and employees who retire on or after September 1, 1964 at or after age 65, will have continuing group life insurance in amounts determined as follows:

(1) Reduction Formula and Minimum Amount

On the first day of the calendar month following the month in which the 65th birthday of an employee or retired employee insured for group life insurance under this Program occurs, the amount of group life insurance which he had under this program on his 65th birthday shall be reduced by 2% thereof, and shall be further reduced by an equal amount on the first day of each succeeding month in accordance with (a) or (b) below; provided, however, that effective October 29, 1979 for employees and for retired employees who retire on or after October 29, 1979, if such employee

or retired employee continues to work after age 65 and the amount of the employee's group life insurance changes because of a change in the employee's pay rate, the employee's group life insurance in force and the amount of each monthly reduction shall be determined as though the amount of the employee's group life insurance applicable to the most recent pay rate had been the amount in force at age 65:

(a) if the employee or retired employee has 10 or more years of credited service, such reductions shall be made until the amount of his group life insurance under this Program is reduced to 1-1/2% of the amount he had on his 65th birthday (or effective October 29, 1979 for employees and for retired employees who retire on or after October 29, 1979, the amount determined from the Schedule of Benefits and the employee's base rate as of the last day the employee is actively at work), multiplied:

(i) if he last worked prior to October 1, 1975, by the number of years of credited service not in excess of 20 that he had at his 65th birthday if he retired prior to October 29, 1979 or by the number of years of credited service not in excess of 20 that he had on his 70th birthday if he retired on or after October 29, 1979 and before May 16, 1988, but in no event to less than \$3,000; or

(ii) if he last worked on or after October 1, 1975, by the number of years of credited service that he had at his 68th birthday if he retired prior to October 29, 1979 or by the number of years of credited service that he had on his 70th birthday if he retired on or after October 29, 1979 and before May 16, 1988, but in no event to less than \$3,000; or

(iii) if he retires on or after May 16, 1988, by the number of years of credited service that he has under the Pension Plan, but in no event less than \$3,500 if he retires prior to November 19, 1990; \$4,500 if he retires on or after November 19, 1990 and before October 18, 1993; or \$5,000 if he retires on or after October 18, 1993

and in any event such remaining amount of group life insurance will be continued thereafter for the remainder of his lifetime; or

(b) if the employee has less than 10 years of credited service, such reductions shall be made until his employment with the Company terminates, and any amount of his group life insurance remaining when his employment with the Company terminates shall then be discontinued; provided, however, that if on or after October 1, 1975 such an employee attains 10 years of credited service after his 65th birthday, his life insurance shall after his 65th birthday be reduced and continued as provided in B.(1)(a) above.

(Credited service shall be that which the employee has under the Pension Plan.)

(2) Employment After Age 65

For an employee who continues to work after age 65, group life insurance will be reduced as provided herein, provided, however, the amount of group life insurance in force as long as the employee has Company-paid coverage other than as a retiree shall not be less than the following percentages of the amount in force at age 65 (based on his most recent pay rate):

Age	Percentage of the Amount of Group Life Insurance At Age 65
66 & 10 months but less than 70	57%
70 but less than 75	33%
75 but less than 80	21%
80 but less than 85	15%
85 and above	8%

(3) Newly Insured At Or After Age 65

For purposes of the reduction in life insurance established herein, an employee who becomes insured for group life insurance under this Program at or after age 65 shall be considered as though he had been insured since age 65.

(4) Contributions Beyond Age 65

No contributions by an employee or retiree for group life insurance coverage will be required for any month after the month in which the 65th birthday occurs.

C. Terminal Illness

Terminally ill covered participants may elect to receive a portion of their life insurance proceeds in advance of their deaths. The amount of life coverage that remains in force will be reduced by the amount paid out under the accelerated benefits option. Accelerated benefits may be paid to a covered participant only once.

Under this option covered participants who are diagnosed with a terminal condition may receive a one-time lump sum payment up to the maximum amount allowed under the insurance policy, but in no event shall such maximum amount allowed be less than fifty (50) percent. Under this provision, “terminal illness” means an injury or sickness expected to result in death within twenty-four (24) months without any reasonable prospect of recovery as determined by the insurer, its medical staff or a qualified party selected by the insurer.

The accelerated benefit will be calculated on the amount of life insurance in force when application for the benefit is made, except the maximum benefit would be such maximum amount allowed under the insurance policy, but in no event shall such maximum amount allowed be less than fifty (50) percent, of the continuing group life or ultimate amount for the covered participant whose benefit is in the process of reducing when application is made or whose benefit will begin to reduce during the twenty-four (24) month life expectancy period.

The accelerated benefits option applies to all employees and retirees with coverage provided by the Company. The option does not apply to the following:

(1) individuals who are cash paying for life insurance coverage while a grievance is pending or while on layoff or leave of absence;

(2) permanently and totally disabled individuals who have already drawn on their life insurance benefits;

(3) individuals who have irrevocably assigned their life insurance; and

(4) when all or a portion of the life insurance is to be paid to a former spouse as part of a divorce agreement.

D. Other Life Insurance Provisions – Employees and Retirees

(1) An employee retired on pension under the Pension Plan prior to September 1, 1964, who was insured for group life insurance on the date he retired, continuing group life insurance for the remainder of his lifetime without further contribution from him in the amount of \$3,000.

(2) An employee insured for group life insurance under this Program who on or after September 1, 1964, retires on early pension under the Pension Plan shall have his group life insurance continued without any premium contribution until he reaches age 65, and thereafter his insurance will be reduced as provided above.

(3) An employee who on or after September 1, 1964, is approved for a permanent total disability pension under the Pension Plan prior to age 60, shall on and after February 1, 1971, have his group life insurance continued, or if he is under age 65 and not insured on that date, reinstated and thereafter continued, in either case in the amount in force on the day he last worked and without premium contributions, to his 65th birthday, and after his 65th birthday the group life insurance thus continued will be reduced as provided above.

(4) An employee insured for group life insurance under this Program who ceases to be at active work for reasons other than retirement at or after his 60th birthday and has been so insured from his 60th birthday to the date he ceases to be at active work or who ceases to be at active work for reasons other than retirement before his 60th birthday but is so insured at his 60th birthday, and who in either case has five or more years of credited service under the Pension Plan at the end of the month in which his 60th birthday occurs, may continue his group life insurance to his 65th birthday by contributing at the rate of 50 cents per month per \$1,000 of group life insurance in force.

(5) An employee on layoff or leave of absence who is not insured for group life insurance under this Program and who on or after May 16, 1988, retires before age 65 under the Pension Plan without returning to work from layoff or leave of absence, shall have his group life insurance reinstated on the first day of the month following the month in which his seniority is cancelled because of such retirement, without contribution by the retired employee, in the amount in force on the day he last worked, and after his 65th birthday the group life insurance thus reinstated will be reduced as provided above.

(6) An employee whose group life insurance ceased as provided in Article I, Section 3, E (3)(b) above, who has 10 or more years of credited service and who on or after May 16, 1988 retires under the Pension Plan (other than a deferred pension) without returning to work, shall have his group life insurance reinstated as of the date of commencement of the pension benefits, without contribution by the retired employee, and thereafter the group life insurance thus reinstated will be continued as provided.

(7) An employee retired on pension under the Pension Plan (excluding former employees entitled to or receiving a deferred vested pension, or employees who retired on or after attaining age 65 with less than 10 years of credited service), who is not insured for group life insurance under this Program and who is living on or after October 18, 1993, will have continuing group life insurance in the amount of \$3,000.

Payment of the amount of group life insurance, less any payment made at the discretion of the insurance company for funeral and other expenses incidental to the employee's or retired employee's illness and death, shall be made in one sum.

Section 2. Survivor Income Benefit

A. Transition Benefit

(1) Eligibility

A Transition Benefit will be paid to the survivor or survivors, as defined herein, of an employee (which term for purposes of paragraphs A. and B. of this Section only, shall include an employee retired on a permanent and total disability pension under the Pension Plan who has not attained the age of 65) who dies while insured for group life insurance under this Program, provided there are survivors living to receive it. The benefit will commence on the first day of the month following the death of the employee, and continue for not more than 24 months.

(2) Definitions

(a) A "Class A Survivor" means the spouse of a deceased male employee and a "Class B

Survivor” means the spouse of a deceased female employee, but only if the survivor was legally married to the deceased employee immediately prior to the employee’s death.

(b) A “Class C Survivor” means any child of the deceased employee who at the time a Transition Benefit first becomes payable to him is both unmarried and either (i) under 21 years of age, or (ii) at least 21 but under age 25 or (iii) totally and permanently disabled at any age over 21; provided, however, that a child under the clause (ii) or (iii) must have been legally residing with and dependent upon the employee at the time of his death, but such child shall cease to be a Class C Survivor upon marrying, or if not totally and permanently disabled upon reaching his or her 25th birthday;

(c) A “Class D Survivor” means a parent of the deceased employee for whom the employee had, during the calendar year preceding the employee’s death, provided at least 50% of the parent’s support;

(3) Benefit Amount

The amount of the Transition Benefit shall be \$700 (\$650 with respect to an employee at work on September 29, 2003 through September 14, 2007 and \$600 with respect to employees at work prior to September 29, 2003), for any month for which no eligible survivor or survivors of the deceased employee are eligible for an unreduced old-age benefit, survivor’s benefit not reduced because of age or disability benefit under the Federal Social Security Act as now in effect or as hereafter amended (hereinafter called the Federal Social Security Act), and shall be \$375 (\$350 with respect to an employee

at work on September 29, 2003 through September 14, 2007 and \$325 with respect to employees at work prior to September 29, 2003), for any month for which any eligible survivor or survivors are eligible for such a benefit under the Federal Social Security Act, except that for months in which two or more survivors share a Transition Benefit immediately following the death of the employee, each survivor's share is computed as a fraction of the Transition Benefit that would be paid to him as a sole survivor, according to his own eligibility for Social Security benefits:

(4) Benefit Payment

The Transition Benefit shall be provided without employee contribution and shall be paid as follows:

(a) if the employee is survived by a Class A Survivor or by a Class B Survivor, the monthly income shall be payable to such survivor; provided, however, that a Class A or Class B Survivor shall not be paid the monthly income for any month for which a higher surviving spouse benefit is payable to the Class A or Class B Survivor under Section (9) of the Pension Plan, and surviving spouse benefits so paid shall be counted as if paid under this Section for the purpose of determining the maximum number of Transition Benefit payments payable; if the employee is not survived by a Class A Survivor or a Class B Survivor, the monthly income shall be payable to the employee's Class C Survivors, but if the employee is not survived by a Class C Survivor, to the employee's Class D Survivors;

(b) if a Class A or Class B Survivor dies while monthly income payments are still payable, any remaining payments will be made, in equal shares,

to the employee's then surviving Class C Survivors; but if none are then surviving, in equal shares to the employee's then surviving Class D Survivors; but if none is then surviving, no further monthly income payments shall be made;

(c) if a Class C Survivor dies while monthly income payments are still payable, and if any other Class C Survivors are still alive, the monthly income which the deceased Class C Survivor had been receiving shall be paid in equal shares to the then surviving Class C Survivor;

(d) if a Class C Survivor dies while monthly income payments are still payable, and if he is not survived by another Class C Survivor, any remaining payments will be made, in equal shares, to any Class D Survivors then surviving, but if no Class D Survivor is then surviving, no further monthly income payments shall be made;

(e) if a Class D Survivor dies while monthly income payments are still payable, and if he is survived by another Class D Survivor, the monthly amount which the deceased Class D Survivor had been receiving shall be added to the amount being received by the surviving Class D Survivor; and

(f) if a Class D Survivor dies while monthly income payments are still payable, and he is not survived by another Class D Survivor, no further monthly income payments shall be made;

B. Bridge Benefit

A Bridge Benefit will be paid to a Class A Survivor or the Class B Survivor, both terms as defined above,

who has received 24 monthly payments of the Transition Benefit.

(1) Benefit Amount

A Bridge Benefit of \$700 per month (\$650 per month with respect to an employee at work on September 29, 2003 through September 14, 2007 and \$600 with respect to employees at work prior to September 29, 2003), will be payable as described below;

(a) the Bridge Benefit will become payable commencing with the first month following the month for which the 24th monthly payment of the Transition Benefit is paid, unless at that time the Class A or Class B Survivor is eligible to receive Mother's Insurance Benefits or a comparable benefit for a father, whether or not called a Father's Insurance Benefit under the Federal Social Security Act, in which case payment of the Bridge Benefit shall be deferred until the Class A or Class B Survivor ceases to be eligible to receive such Mother's Insurance Benefits or a comparable benefit for a father, whether or not called a Father's Insurance Benefit; provided, however, that a Class A or Class B Survivor of an employee shall not be paid the Bridge Benefit for any month for which a higher surviving spouse benefit is payable to the Class A or Class B Survivor under Section (9) of the Pension Plan; and

(b) the Bridge Benefit will not be paid beyond the earliest to occur of the following: (i) the death or remarriage of the Class A Survivor or Class B Survivor or (ii) attainment by the Class A Survivor or Class B Survivor of age 62 (age 62 and one month if such survivor receives an initial Social Security Old-Age Insurance Benefit which is paid during the

second month following the survivor's 62nd birthday) or such lower age at which full Widow's or Widower's Insurance Benefits become payable under the Federal Social Security Act.

Section 3. Optional Group Life Insurance

A. Employee Optional Group Life Insurance

(1) Eligibility Date

An employee, other than a salaried employee, shall become eligible for optional group life insurance on the later of (a) the day active employment commences, and (b) the day the employee becomes an hourly employee. The date the employee becomes eligible for optional group life insurance shall be hereinafter referred to as the employee's eligibility date.

(2) Enrollment and Effective Dates

The employee's optional group life insurance shall become effective as set forth below:

(a) If the employee enrolls on or before his eligibility date or during the thirty-one (31)-day period following his eligibility date, insurance becomes effective on the first day of the calendar month following the month in which the employee enrolls. If the employee enrolls for coverage in excess of the guaranteed issue amount, the employee must furnish satisfactory evidence of insurability, and such excess coverage becomes effective the date the Insurance Company approves the excess coverage.

(b) If the employee enrolls subsequent to the thirty-first (31st) day following his eligibility date, or if the employee becomes insured for optional group life insurance and later decides to enroll for a higher amount of insurance as set forth in (3) below, the employee must furnish satisfactory evidence of insurability to the Insurance Company. In the event the Insurance Company approves the evidence, the employee's coverage becomes effective the date of the Insurance Company's approval.

(c) If the employee enrolls in coverage or requests an increase in coverage within thirty-one (31) days of a family status change because the employee has married or acquired children by birth or adoption, the coverage or increase becomes effective on the first day of the calendar month following the month in which the employee enrolls. If the employee enrolls for coverage in excess of the guaranteed issue amount, as referenced in (f) below, the employee must furnish satisfactory evidence of insurability, and such excess coverage becomes effective the date the Insurance Company approves the excess coverage.

(d) In any event, for an employee to become insured initially or for a higher amount of insurance, he must be actively at work on the date the insurance or higher amount of insurance would otherwise become effective. If the employee is not actively at work on such date, the insurance or higher amount of insurance becomes effective on the date the employee returns to active work, provided he is then still eligible as set forth in (1) above.

(e) If the employee becomes insured for optional group life insurance and later enrolls for a lower amount of insurance as set forth in (3) below, the

lower amount of insurance will become effective on the first day of the calendar month following the month in which the employee enrolls for the lower amount of insurance, whether or not the employee is then actively at work.

(f) Effective January 1, 2020, the optional group life guaranteed issue amount for an employee is \$300,000.

(3) Amount of Insurance

The employee may elect a level of coverage from the schedules of optional group life insurance as contained in the Life Insurance Administration Manual. As of January 1, 2020, all employees, regardless of annual base salary, may elect up to \$300,000 of Optional Group Life Insurance. Employees may elect higher coverage (up to \$500,000), provided such level of coverage does not exceed ten (10) times the employee's annual base salary.

(4) Contributions

The employee shall contribute the full cost of optional group life insurance. Contributions shall be payable through payroll deductions while actively at work. Payroll deductions may also be taken from sickness and accident benefits and supplemental unemployment benefits paid through the Company's payroll processes. An arrearage procedure will be used to ensure that missed contributions are taken from future sickness and accident benefits, supplemental unemployment benefits or regular payroll wages that are or become payable to the employee, or, if no such benefits or wages are or become payable to the employee, a direct bill process

will be utilized. For employees receiving extended disability benefit payments, a direct bill process will be utilized. If an employee chooses to continue coverage upon retirement, monthly contributions will be taken through pension deductions, or, if the pension benefit is insufficient to cover the contribution, a direct bill process will be utilized. The required monthly contribution, which is not subject to change during the duration of this Collective Bargaining Agreement is set forth in the Life Insurance Administration Manual.

When the employee attains a birthday which places him in a higher age bracket, the monthly contribution will change on the first day of the calendar month following the month in which such birthday occurs.

(5) Benefit Payment

If the employee dies from any cause while insured for optional group life insurance, the amount of such insurance shall be paid to the person or persons designated by the employee as beneficiary. The beneficiary is that designation the employee has last made as indicated on the records of the Insurance Company.

Optional Group Life Insurance shall be paid in one lump sum.

(6) Terminally Ill Employees and Retirees

Terminally ill employees and retirees may elect to receive a portion of their life insurance proceeds in advance of their deaths. The amount of life coverage that remains in force will be reduced by the amount paid out under the accelerated benefits option.

Accelerated benefits may be paid to an employee or retiree only once.

Under this option insured employees and retirees who are diagnosed with a terminal condition may receive a one-time lump sum payment up to the maximum amount allowed under the insurance policy, but in no event shall such maximum amount allowed be less than fifty (50) percent. The accelerated benefit will be calculated on the amount of life insurance in force when application for the benefit is made. Under this provision, "terminal illness" means an injury or sickness expected to result in death within twenty-four (24) months without any reasonable prospect of recovery as determined by the insurer, its medical staff or a qualified party selected by the insurer.

The option will not apply to the following:

(a) Individuals who have irrevocably assigned their life insurance; and

(b) when all or a portion of the life insurance is to be paid to a former spouse as part of a divorce agreement.

(7) Miscellaneous Provisions

The employee's insurance certificate shall set forth the administrative provisions regarding the recording of beneficiary designations, changes of beneficiary and the procedure for payment of insurance in case there is no beneficiary living at the death of the employee.

This insurance is term insurance without cash, loan or paid-up values.

(8) Continuation of Insurance

An employee may continue optional group life insurance after the last month for which a payroll deduction was made, while on layoff, leave of absence or retirement, by paying the required monthly contribution in accordance with (4) herein, subject to the following time limits:

(a) For twelve (12) months, if the employee is on an approved personal leave of absence;

(b) For the period of the leave, if the employee is on an approved leave of absence to work for the International or Local Union;

(c) For the period, not to exceed twelve (12) months, twenty-four (24) months for an employee who has ten (10) or more years of seniority as of the last day worked prior to layoff equal to that for which he may be covered for non-contributory coverage under Article I., Section 3.E.(1) of this Program, and thereafter for twelve (12) additional months, if the employee is laid off;

(d) For the period equal to the lesser of (i) his period of disability or (ii) his seniority, if the employee is on an approved disability leave of absence; and

(e) For the period of retirement.

(9) Cessation of Insurance

Optional group life insurance shall automatically cease on the earliest of the following:

(a) If the employee or retired employee fails to

make a required contribution for optional group life insurance when due, the last day of the calendar month immediately preceding the calendar month for which such contribution was due.

(b) The date of discontinuance of optional group life insurance under the Program.

(10) Conversion Privilege

Upon written application made to the Insurance Company within thirty-one (31) days after the date of cessation of the employee's optional group life insurance because of cessation of the employee's eligibility for optional group life insurance (unless such cessation was due to discontinuance of optional group life insurance under the program), the employee shall be entitled to have an individual policy of life insurance only, without disability or accidental means death benefits, issued by the Insurance Company, without evidence of insurability. Such individual policy shall be upon one of the forms then customarily issued by the Insurance Company, except term insurance, and the premium for such individual policy shall be the premium applicable to the class of risk to which the employee belongs and to the form and amount of the individual policy at the employee's attained age at the date of issue of such individual policy.

The amount of such individual policy shall be equal to (or, at the option of the employee, less than) the amount of optional group life insurance on the date of cessation of such insurance.

Any individual policy of life insurance so issued shall become effective at the end of the thirty-one (31)-day period during which application for such individual

policy may be made. If, however, the employee dies during such thirty-one (31)-day period, the Insurance Company shall pay to the employee's beneficiary of record, whether or not application for such individual policy shall have been made, the maximum amount of life insurance for which an individual policy could have been issued.

(11) Data

Relevant data will be provided pursuant to Article I, Section 3. I.

(12) Procedure for Review of Denied Claims

If a claim for optional group Life Insurance is denied, a notice will be sent explaining the reason for the denial. If there are any questions concerning the denial, inquiry should be made within sixty (60) days from the date the claim was denied to the office that denied the claim, furnishing all information supporting the appeal. The appeal will be reviewed by that office and a reply made within sixty (60) days after receipt of the appeal.

B. Dependent Optional Group Life Insurance

(1) Eligibility Date

An employee, other than a salaried employee, shall become eligible for dependent group life insurance on the later of (a) the day active employment commences, and (b) the day the employee becomes an hourly employee, provided that the employee has at least one (1) eligible dependent as defined in (3) below. If the employee does not then have such a dependent, he shall become eligible for dependent

group life insurance on the day this condition is first met. The date the employee becomes eligible for dependent group life insurance shall be hereinafter referred to as the employee's eligibility date.

(2) Enrollment and Effective Dates

The employee's dependent group life insurance shall become effective as set forth below:

(a) If the employee enrolls on or before his eligibility date or during the thirty-one (31)-day period following his eligibility date, insurance becomes effective on the first day of the calendar month following the month in which the employee enrolls.

(b) If the employee enrolls subsequent to the thirty-first (31st) day following his eligibility date, or if the employee becomes insured for dependent group life insurance and later decides to enroll for higher amounts of insurance, the employee must furnish satisfactory evidence of insurability to the Insurance Company for each dependent. In the event the Insurance Company approves the evidence, the dependent coverage will become effective the date of the Insurance Company's approval, provided those persons whose evidence has been approved are still eligible dependents, as defined in (3) below.

(c) If the employee enrolls in coverage or requests an increase in coverage within thirty-one (31) days of a family status change because the employee has married or acquired children by birth or adoption, the coverage or increase becomes effective on the first day of the calendar month following the month in which the employee enrolls.

(d) An employee must be actively at work on the effective date of coverage as provided in (a), (b) or (c) above, and if the employee is not actively at work on such date, such coverage will not become effective until the date the employee returns to active work, provided the employee is still eligible as provided in (1) above.

(e) If the employee becomes insured for dependent group life insurance and later enrolls for lower amounts of insurance, the lower amounts of insurance will become effective on the first day of the calendar month following the month in which the employee makes such enrollment.

(f) Effective March 1, 2016, the guaranteed issue amount for spouse coverage is \$100,000 and for child coverage is \$80,000.

(3) Definition of Dependent

A dependent shall mean the spouse or child of the employee as defined below:

(a) "Spouse" means: The employee's lawful spouse. "Discontinuation of Same-Sex Domestic Partner Status" pursuant to Letter C-41 of Exhibit B applies to this Section 3.

(b) "Child" means: (i) the employee's natural child; (ii) the employee's adopted child, including a child from the date of placement with the adopting parents until the legal adoption; (iii) the child of the employee's spouse; (iv) an unmarried child for whom the employee has been legally appointed guardian who resides with and is supported by the employee or (v) the employee's unmarried foster child who resides

with and is supported by the employee. A child as defined in (i), (ii), (iii), (iv), or (v) is included until the end of the month in which the child attains age twenty-six (26). A child as defined in (i), (ii) or (iii) who is totally and permanently disabled as defined hereinafter is included regardless of age, provided that any such child prior to attaining age twenty-six (26) must be dependent upon the employee within the meaning of the Internal Revenue Code of the United States and must legally reside with, and be a member of the household of, the employee. "Totally and permanently disabled" means having any medically determinable physical or mental condition which prevents the child from engaging in substantial gainful activity and which can be expected to result in death or to be of long-continued or indefinite duration.

Notwithstanding sections (a) and (b) above, an employee of the Company who is also a child of an employee of the Company is not an eligible child for coverage under dependent group life, regardless of age. Additionally, a dependent may not be covered as a spouse by one employee and as a child by another employee. Furthermore, a child can only be covered by one employee under this dependent group life plan.

For the purposes of dependent life insurance continued as set forth in (8), (b) herein, a child born after the employee's death shall be an eligible dependent only if such child is the issue of the surviving spouse's marriage to the deceased employee, and was conceived prior to such employee's death. Any such child shall be eligible on the same basis as a child born prior to the employee's death.

The definition of dependent used in this Section shall apply only to the dependent group life insurance

set forth herein and shall be entirely independent of any such definition used for the hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverage set forth in Article III of the Program.

(4) Amount of Insurance

No increase in the amount of insurance in force on account of any dependent will occur after the employee's death.

(5) Contributions

The employee shall contribute the full cost of dependent group life insurance. Contributions shall be payable through payroll deductions while actively at work. Payroll deductions may also be taken from sickness and accident benefits and supplemental unemployment benefits paid through the Company's payroll processes. An arrearage procedure will be used to ensure that missed contributions are taken from future sickness and accident benefits, supplemental unemployment benefits or regular payroll wages that are or become payable to the employee, or, if no such benefits or wages are or become payable to the employee, a direct bill process will be utilized. For employees receiving extended disability benefit payments, a direct bill process will be utilized. If an employee chooses to continue coverage upon retirement, monthly contributions will be taken through pension deductions, or, if the pension benefit is insufficient to cover the contribution, a direct bill process will be utilized. The required monthly contribution, which is not subject to change during the duration of this Collective Bargaining Agreement (regardless of the number of dependent children on whose account the employee is insured), is as set

forth in the Life Insurance Administration Manual.

When the employee attains a birthday which places him in a higher age bracket, the monthly contribution for spouse coverage will change on the first day of the calendar month following the month in which such birthday occurs.

Monthly contributions will continue until the end of the month in which the employee or retired employee contacts the life insurance administrator to advise the employee or retired employee has ceased to have an eligible spouse and/or child(ren) as defined in (3) above.

In the case of dependent group life insurance continued after the employee's death, the surviving spouse shall contribute the full cost of such insurance. The spouse must make the required contributions directly to the life insurance administrator. For spouse coverage, the monthly rate of contribution for any such surviving spouse will be determined under the applicable Schedule, based on the progressing age of the deceased employee, as though he continued to be living; provided however, that for deaths on or after October 14, 1996, the monthly rate of contribution for spouse coverage will be determined based on the progressing age of the surviving spouse. For child coverage, the monthly rate of contribution will be that which is the current contribution amount for child coverage as set forth in the Life Insurance Administration Manual.

(6) Payment of Benefits

(a) If a dependent dies from any cause while the employee is insured for dependent group life

insurance, the amount of such insurance in force on account of the dependent shall be paid to the employee. Payment shall be made in a lump sum. The employee's insurance certificate shall set forth the procedure for payment of insurance in case a dependent dies subsequent to the death of the employee.

(b) If a dependent child dies from any cause while dependent group life insurance is being continued as set forth in (8), (b) herein, the insurance in force on account of the dependent child shall be paid in a lump sum to the surviving spouse of the employee.

(c) If the surviving spouse dies from any cause while dependent life insurance is being continued as set forth in (8), (b) herein, the insurance in force on account of the surviving spouse shall be paid to the spouse's beneficiary of record if one has been designated, otherwise to the estate of the surviving spouse. Payment shall be made in a lump sum.

(d) The surviving spouse's insurance certificate shall set forth the administrative provisions regarding the recording of beneficiary designations, changes of beneficiary and the procedure for payment of insurance in case there is no beneficiary living at the death of the dependent.

(e) In no event will more than one claim be paid hereunder on account of the death of any insured person.

(f) This insurance is term insurance without cash, loan or paid-up values.

(7) Terminally Ill Dependents

For terminally ill dependents, employees and retirees may elect to receive a portion of the life insurance proceeds in advance of their dependent's death. The same terms and conditions outlined in A. (6) above for employee optional group life insurance apply to dependent optional group life insurance.

(8) Continuation of Insurance

(a) An employee may continue dependent group life insurance after the last month for which a payroll deduction was made, while on layoff, leave of absence or retirement, by paying the required monthly contribution in accordance with (5) herein, subject to the following time limits:

(i) For twelve (12) months, if the employee is on an approved personal leave of absence;

(ii) For the period of the leave, if the employee is on an approved leave of absence to work for the International or Local Union;

(iii) For the period, not to exceed twelve (12) months, twenty-four (24) months for an employee who has ten (10) or more years of seniority as of the last day worked prior to layoff, equal to that for which he may be covered for non-contributory coverage under Article I, Section 3., E. (1) of this Program, and thereafter for twelve (12) additional months, if the employee is laid off;

(iv) For the period equal to the lesser of (1) his period of disability or (2) his seniority, if the employee is on an approved disability leave of absence; and

(v) For the period of retirement.

(b) In the event an employee dies while insured for dependent group life insurance, the insurance in force as of the date of the employee's death may be continued only by the surviving spouse of an employee for themselves and any dependent child(ren), as set forth in Section III.

(9) Cessation of Insurance

(a) An employee's dependent group life insurance shall automatically cease on the earliest of the following:

(i) The date the employee or retired employee ceases to have a dependent as defined in (3) above.

(ii) If the employee or retired employee fails to make a required contribution for dependent group life insurance when due, the last day of the calendar month immediately preceding the calendar month for which such contribution was due.

(iii) The last day of the calendar month in which the employee terminates employment.

(iv) The date of discontinuance of dependent group life insurance under the Program.

(b) Any dependent group life insurance continued in accordance with the provisions of (8), (b) herein, shall automatically cease on the earliest of the following:

(i) The date of the surviving spouse's remarriage.

(ii) The date the surviving spouse dies.

(iii) If the surviving spouse fails to make a required contribution as set forth above when due, the last day of the calendar month immediately preceding the calendar month for which such contribution was due.

(iv) The date of discontinuance of dependent group life insurance under the Program.

(c) The dependent group life insurance on account of any dependent shall, in any case, automatically cease on the day immediately preceding the date such person ceases to be a dependent as defined in (3) herein.

(10) Conversion Privilege

Upon written application made by a person to the Insurance Company within thirty-one (31) days after the date of cessation of the dependent group life insurance on account of such person because of:

(a) The employee's death or cessation of the employee's eligibility for dependent group life insurance unless such cessation was due to discontinuance of dependent group life insurance under the Program, or

(b) Cessation of dependent group life insurance in accordance with (9) herein, or

(c) Such person's ceasing to be a dependent as defined in (3) herein, such person shall be entitled to have an individual policy of life insurance only, without disability or accidental means death benefits,

issued by the Insurance Company, without evidence of insurability. Such individual policy shall be upon one of the forms then customarily issued by the insurance company, except term insurance, and the premium for such individual policy shall be the premium applicable to the class of risk to which such person belongs and to the form and amount of the individual policy at such person's attained age at the date of issue of such individual policy.

The amount of such individual policy shall be equal to (or at the option of such person less than) the amount of dependent group life insurance in force on account of such person on the date of cessation of such insurance.

Any individual policy of life insurance so issued shall become effective at the end of the thirty-one (31)-day period during which application for such individual policy may be made. If, however, the person who is entitled to the privilege of obtaining an individual policy of life insurance dies during such thirty-one (31)-day period, the Insurance Company shall pay benefits in accordance with (6) herein, as though the insurance had been in force, whether or not application for such individual policy shall have been made, the maximum amount of life insurance for which an individual policy could have been issued. The employee's insurance certificate shall set forth the procedure for payment of insurance in case such person dies subsequent to the death of the employee.

(11) Data

Relevant data will be provided pursuant to Article I, Section 3. I.

(12) Procedure for Review of Denied Claims

If a claim for dependent group life insurance is denied, a notice will be sent explaining the reason for the denial. If there are any questions concerning the denial, inquiry should be made within sixty (60) days from the date the claim was denied to the office that denied the claim, furnishing all information supporting the appeal. The appeal will be reviewed by that office and a reply made within sixty (60) days after receipt of the appeal.

Section 4. Group Accidental Death and Dismemberment Insurance

The group accidental death and dismemberment insurance referred to in Article I. hereof or any group accidental death and dismemberment insurance policy or policies issued in lieu thereof shall, for the period of this Program include the following:

A. Eligibility

Group accidental death and dismemberment insurance coverage shall be provided, in the amounts and under the circumstances set forth below, for employees and to employees who retire prior to age 65, while insured for life insurance under Section 1. above, without contribution, except that coverage for an employee shall be continued during any period of employment after age 65, subject to a reduction of the benefit during such period corresponding with the reduced amount of life insurance then in force for such employee. Accidental death and dismemberment insurance coverage shall not be continued beyond the end of the month in which a retired employee becomes age 65.

B. Benefit Amount

If the employee or retired employee has an accidental bodily injury and dies or incurs any of the other losses described below as a result of, and dies within one year of or incurs any of the other losses within two years of such accident, the employee or his designated beneficiary shall receive the following benefits, provided the employee is insured for this coverage at the time of such injury and at the time of such loss:

Loss	Accidental Death and Dismemberment Benefits
Accidental death or accidental loss of more than one of the following: hand, foot, or sight of an eye	Equal to one-half life insurance in force
Accidental loss of one of the following: hand, foot, or sight of an eye	Equal to one-quarter life insurance in force

provided, however, that if loss of life results from accidental bodily injuries caused solely by employment with the Company, and results solely from an accident in which the cause and result are unexpected and definite as to time and place, the amount payable as an accidental death and dismemberment benefit shall be an amount equal to one and one-half times the amount of life insurance in force for the employee at the date of the accident;

C. Benefit Payment

Payment shall be made in one sum.

D. Definitions

For purposes of determining eligibility for benefits the following shall apply:

(1) loss of a hand or a foot means loss by severance at or above the wrist or ankle joint;

(2) loss of sight of an eye means total and irrecoverable loss of sight.

E. Limitation

The total amount payable on account of more than one of the losses listed in B. above sustained in any one accident shall not exceed an amount equal to one-half the life insurance in force, except that in the event of loss of life resulting from accidental bodily injuries caused solely by employment with the Company, the total amount payable as an accidental death and dismemberment benefit on account of such accident shall not exceed an amount equal to one and one-half times the amount of life insurance in force for the employee at the date of the accident;

F. Exclusions

No payment shall be made under the accidental death and dismemberment insurance for any loss caused wholly or partly, directly or indirectly, by:

(1) disease, or bodily or mental infirmity, or medical or surgical treatment thereof,

(2) any infection, except infection caused by an external visible wound accidentally sustained,

(3) self-destruction or intentionally self-inflicted injury, while sane or insane,

(4) war, or any act of war, whether declared or undeclared, or

(5) the employee's act of aggression, participation in a felonious enterprise or illegal use of drugs.

G. Examination

In the case of dismemberment claims, the Insurance Company has the right as often as it may reasonably require to examine the person of the employee at its expense while the claim is pending, and that in the case of accidental death claims it has the right to make an autopsy, where not forbidden by law.

H. Assignment

Accidental death and dismemberment insurance is not assignable unless the assignment is made in writing and consented to by the Insurance Company in writing.

Section 5. Employee Optional Group Accident Insurance

A. Eligibility Date

An employee shall become eligible for optional group accident insurance as described herein for the amounts of insurance therein described, on the later of (1) the day active employment commences, and (2) the day the employee becomes a UAW-represented

employee covered by this Collective Bargaining Agreement. The date the employee becomes eligible for optional group accident insurance shall be hereinafter referred to as the employee's eligibility date.

B. Enrollment and Effective Dates

The employee's optional group accident insurance shall become effective as set forth below:

(1) If the employee enrolls on or before the employee's eligibility date, insurance becomes effective on the first day of the calendar month following the month in which the employee enrolls.

(2) If the employee enrolls subsequent to the employee's eligibility date, or if the employee becomes insured for optional group accident insurance and later decides to enroll for a higher amount of insurance as set forth in C. below, insurance will become effective on the first day of the calendar month following the month in which the employee enrolls.

(3) In any event, for an employee to become insured initially or for a higher amount of insurance, the employee must be actively at work on the date the insurance would otherwise become effective. If the employee is not actively at work on such date, the insurance or higher amount of insurance becomes effective on the date the employee returns to active work, provided the employee is then still eligible as set forth in A. above.

(4) If the employee becomes insured for optional group accident insurance and later enrolls for a lower amount of insurance as set forth in C. below, the lower

amount of insurance will become effective on the first day of the calendar month following the month in which the employee enrolls for the lower amount of insurance, whether or not the employee is then actively at work.

C. Amount of Insurance

The employee may elect either employee coverage or family coverage. Coverage must be purchased in units of \$10,000. Employees may buy a principal sum of up to ten (10) times annual base pay, rounded to the next \$10,000, up to a maximum benefit of \$1,000,000.

(1) Loss of Life or a Bodily injury.

If the employee sustains an accidental bodily injury which results in one of the following losses within three hundred sixty-five (365) days of the accident, the following schedule applies:

Loss of life	The Principal Sum
Loss of both hands or both feet.....	The Principal Sum
Loss of one hand and one foot.....	The Principal Sum
Loss of entire sight of both eyes.....	The Principal Sum
Loss of speech and hearing	The Principal Sum
Loss of the entire sight of one eye and one hand or foot	The Principal Sum
Loss of one hand or one foot.....	One-Half The Principal Sum
Loss of the entire sight of one eye	One-Half The Principal Sum
Loss of speech or hearing	One-Half The Principal Sum
Loss of thumb and index finger (of the same hand)	One-Quarter The Principal Sum

If the employee elects family coverage, both the employee and eligible family members are insured; if there are no children, the spouse is covered for an

amount equal to sixty percent (60%) of the employee's coverage. If there is no spouse, each eligible child is covered for twenty percent (20%) of the employee's coverage. If both a spouse and one or more children are covered, the spouse is covered for an amount equal to fifty percent (50%) of the employee's coverage and each child is covered for an amount equal to fifteen percent (15%) of the employee's coverage.

Benefits under this provision will not be paid under any circumstances for more than one of the losses, the greatest, sustained by the covered employee or covered family member as the result of any one injury.

"Loss," as used with reference to hand or foot, means complete severance through or above the wrist or ankle joint; as used with reference to eye, means irrecoverable loss of the entire sight thereof; as used with reference to speech and hearing, means entire and irrecoverable loss of speech and hearing; and as used with reference to thumb and index finger, means complete severance through or above metacarpophalangeal joints.

For losses sustained on or after October 14, 1996, the benefits described in C. (2) through (7) apply:

(2) Paralysis Benefits

If an insured employee sustains an accidental bodily injury that results in permanent paralysis within three hundred sixty-five (365) days of the accident, the following schedule applies:

Quadriplegia	The Principal Sum
Paraplegia	Three-Quarters The Principal Sum
Hemiplegia	One-Half The Principal Sum

If the employee elects family coverage and there are no children, the spouse is covered for an amount equal to sixty percent (60%) of the employee's coverage and, if there is no spouse, each eligible child is covered for twenty percent (20%) of the employee's coverage. If there is a spouse and one or more children, the spouse is covered for an amount equal to fifty percent (50%) of the employee's coverage and each eligible child is covered for fifteen percent (15%) of the employee's coverage.

If an insured employee sustains an accidental bodily injury that results in a permanent paralysis within three hundred sixty-five (365) days of the accident, and less than The Principal Sum is payable by reason of such loss, and the insured employee thereafter suffers a greater loss as a result of the same accidental bodily injury within such three hundred sixty-five (365) day period following the accident, the excess benefit amount will be payable.

(3) Comatose Benefit

If an insured employee sustains an accidental bodily injury that results in a lapse into a comatose state within three hundred sixty-five (365) days of the accident, a benefit equal to two percent (2%) of the Principal Sum shall be payable on the thirty-second (32nd) day of the coma and each month thereafter for a maximum of fifty (50) months, or until death, if earlier, at which time any balance would be paid. If the employee regains consciousness, benefits shall cease and coverage for optional group accident insurance would resume only upon re-enrollment and payment of premiums.

If the employee elects family coverage, the spouse is covered for an amount equal to fifty percent (50%) of the employee's coverage and each eligible child is covered for ten percent (10%) of the employee's coverage.

(4) Special Education Benefit

If family coverage has been elected and the insured employee dies as a result of a covered accident, an additional benefit in the amount of ten percent (10%) of the employee's Principal Sum (subject to a maximum of \$20,000) per year for up to four (4) years will be paid for each eligible dependent child enrolled within three hundred sixty-five (365) days of the death of the employee as a full-time student in an accredited college or university.

This benefit is payable annually for a maximum of four(4)consecutive years, providing the eligible child consecutively continues his/her education as a full-time student. Benefits beyond the first year require evidence that the child has successfully completed all academic requirements of the prior school year.

No payment will be made for room, board, or other living, traveling, or clothing expenses and, if there is no dependent child who qualifies, an additional benefit of \$1,000 will be paid to the beneficiary.

(5) Special Child Care Center Benefits

If family coverage has been elected, upon the death of an insured employee or insured spouse from a covered accident, the beneficiary will receive an additional benefit in the amount of five percent (5%) of the employee's Principal Sum (subject to a maximum

of \$7,500) per year for up to four (4) years for each eligible dependent child, under the age of thirteen (13), enrolled (or who becomes enrolled within ninety (90) days) in a qualified child care center.

If there is no dependent child who qualifies, an additional benefit of \$1,000 will be paid to the beneficiary.

(6) Spousal Occupational Training Expense

If family coverage is elected and the insured employee dies as a result of a covered accident, a surviving spouse who participates in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which the spouse would not have sufficient qualification otherwise, will be reimbursed for expenses actually incurred up to ten percent (10%) of the employee's Principal Sum (subject to a maximum of \$20,000) for up to four (4) years.

To be reimbursed, such expenses must be reasonable and necessary and must be incurred within four (4) years of the date of the death. No payment will be made for room, board, or other living, traveling, or clothing expenses.

(7) Common Disaster Benefit

If family coverage is elected and an insured employee and insured spouse suffer a loss of life in the same covered accident, or separate covered accidents which occur within forty-eight (48) hours of each other (common disaster), the amount payable by reason of the spouse's death will equal the amount payable by reason of the insured employee's death.

The common disaster benefit for the insured employee and insured spouse will not exceed \$1,000,000.

For losses sustained on or after January 1, 2000, the benefit described in (8) and (9) below also shall apply:

(8) Seat Belt & Air Bag Benefit

If an insured dies as a result of a covered accident in which their seat belt was properly used, an additional benefit shall be paid. The benefit paid for the proper use of a seat belt will be an amount equal to ten percent (10%) of the Principal Sum, subject to a maximum of \$25,000. If an air bag is deployed for the seat in which the insured occupied and while properly using a seat belt, an additional benefit amount of 10% of the Principal Amount, subject to a maximum of \$25,000, will also be paid.

(9) Repatriation Expense Benefit

If the insured suffers loss of life as the result of a covered accident, a repatriation benefit, in the amount of \$2,500 (\$5,000 effective January 1, 2004), will be paid for the preparation and transportation of his/her body to the city of his/her principal residence, provided the death occurred at least one hundred (100) miles away from his/her principal residence.

For losses sustained on or after January 1, 2004, the benefit described in (10), (11) and (12) below also shall apply:

(10) Brain Damage Benefit

Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life.

Brain Damage must manifest itself within thirty (30) days of the accidental injury, insured requires a hospitalization of at least five (5) days and brain damage persists for twelve (12) consecutive months after the date of the accidental injury. 100% of the full amount is payable.

(11) Exposure and Disappearance Benefit

Exposure and Disappearance is defined as loss of life due to exposure to natural or chemical elements will be deemed to be accidental if the exposure was a direct result of an accident.

If a person disappears as a direct result of the accident, wrecking or sinking of the conveyance in which he or she was an occupant; and there is no contrary evidence about the circumstances of the disappearance within one (1) year of the accident, the disappearance will be deemed an accidental death.

Benefit level will be the full in-force amount.

(12) Travel Assist

Travel assistance will be provided to employee or eligible family member(s) for the following types of services:

Emergency medical assistance including medical evacuation, medically supervised repatriation, replacement of lost medication, hospital admission service, medical consultation, and critical care monitoring;

Emergency message transmission, emergency transportation to join patient, return of mortal remains, as well as legal and transportation services.

D. Exclusions

The policy does not cover loss caused or contributed by:

(1) Suicide or self-destruction or any attempt thereat, whether sane or insane;

(2) Bodily infirmity, sickness or disease;

(3) Medical or surgical treatment (except medical or surgical treatment necessitated only due to an injury);

(4) War, declared or undeclared, or any act of war except while the insured person is outside the United States and Puerto Rico on Company assignment or while insured dependents are outside the United States and Puerto Rico because of the insured's assignment;

(5) Injury sustained while serving in the armed forces of any country, for which period premiums will be refunded; provided, however, that a member of an Organized Reserve Corps or National Guard Unit shall be covered during short periods of training or participation in public ceremonies.

(6) Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft. This policy covers riding as a passenger but not as an operator or crew member, in or on, boarding or unloading from any aircraft having a current and valid airworthiness certificate or any transport-type aircraft operated by the Military Airlift Command (MAC) of the United States of America or by any similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world. Persons who are not members of the operating crew of any aircraft, who are engaged in testing, measuring, calibrating, and similar operations, shall be considered passengers and not crew members;

(7) The insured person's act of aggression, participation in a felonious enterprise, or illegal use of drugs.

E. Contributions

The employee shall contribute the full cost of optional group accident insurance. Contributions shall be payable through payroll deductions while actively at work. Payroll deductions may also be taken from sickness and accident benefits and supplemental unemployment benefits paid through the Company's payroll processes. An arrearage procedure will be used to ensure that missed contributions are taken from future sickness and accident benefits, supplemental unemployment benefits or regular payroll wages that are or become payable to the employee, or, if no such benefits or wages are or become payable to the employee, a direct bill process will be utilized. For employees receiving extended

disability benefit payments, a direct bill process will be utilized. If an employee chooses to continue coverage upon retirement, monthly contributions will be taken through pension deductions, or, if the pension benefit is insufficient to cover the contribution, a direct bill process will be utilized. The required monthly contribution, which is not subject to change during the duration of this Collective Bargaining Agreement, is set forth in the Life Insurance Administration Manual.

If the employee or retired employee is enrolled in family coverage and ceases to have an eligible family member, monthly contributions for family coverage will continue until the end of the month in which the employee or retired employee contacts the life insurance administrator to request a change in coverage.

F. Definition of Family Member

“Family Member” means:

(a) The employee’s lawful spouse. “Discontinuation of Same-Sex Domestic Partner Status” pursuant to Letter C-41 of Exhibit B applies to this Section 5.

(b) Child as follows: (i) the employee’s natural child; (ii) the employee’s adopted child, including a child from the date of placement with the adopting parents until the legal adoption; (iii) the child of the employee’s spouse; (iv) an unmarried child for whom the employee has been legally appointed guardian who resides with and is supported by the employee or (v) the employee’s unmarried foster child who resides with and is supported by the employee. A child as defined in (i), (ii), (iii), (iv) or (v) is included until the end of the month in which the child attains age twenty-six

(26). A child as defined in (i), (ii) or (iii) who is totally and permanently disabled as defined hereinafter is included regardless of age, provided that any such child prior to attaining age twenty-six (26) must be dependent upon the employee within the meaning of the Internal Revenue Code of the United States and must legally reside with, and be a member of the household of, the employee. "Totally and permanently disabled" means having any medically determinable physical or mental condition which prevents the child from engaging in substantial gainful activity and which can be expected to result in death or to be of long-continued or indefinite duration.

No person may be considered a family member of more than one employee. Additionally, notwithstanding (b) above, an employee of the Company who is also a child of an employee of the Company is not an eligible family member for coverage under this optional group accident insurance, regardless of age.

The definition of family member used in this Section shall apply only to the optional group accident insurance set forth herein and shall be entirely independent of any such definition used for benefits as set forth in the Life, Disability and Health Care Benefits Program or any other Program.

G. Payment of Benefits

(1) If an employee dies as a result of accidental death while the employee is insured for optional group accident insurance, the amount of such insurance in force shall be paid to the person or persons designated by the employee as beneficiary. The beneficiary is that designation the employee has last made as indicated on the records of the Insurance Company.

When the Insurance Company receives notice of the beneficiary change, the change then relates back to and takes effect as of the date the employee signed such notice, according to the date shown thereon, whether or not the employee is living when the Insurance Company received such notice, but without prejudice to the Insurance Company on account of any payment it may have made before receipt of such written notice.

In the event the last named beneficiary dies before the employee, or if no beneficiary shall have been named, the optional group accident insurance will be paid to the employee's spouse, if living; if not living, equally to the employee's surviving children; if none survive, to either the employee's mother or father, or to both equally if both survive; if there are no such survivors, to the employee's estate.

(2) If a covered spouse or other family member dies as a result of accidental death while insured for optional group accident insurance, the amount of such insurance in force on account of the family member shall be paid in a lump sum to the employee (the employee is the beneficiary for optional group accident insurance). The employee's insurance certificate shall set forth the procedure for payment of insurance in case a family member dies subsequent to the death of the employee.

(3) All other indemnities are payable to the injured person suffering the loss.

H. Cessation of Insurance

For an employee, optional group accident insurance shall automatically cease on the earlier of the following:

(1) If the employee fails to make the required premium contribution for optional group accident insurance when due, the last day of the calendar month immediately preceding the calendar month for which such contribution was due.

(2) The date of discontinuance of optional group accident insurance under the Insurance Program.

For a family member, other than in the instance of the death of an employee, optional group accident insurance shall automatically cease on the earliest of the following:

(1) On the date of termination of the employee's insurance.

(2) On the date the family member ceases to be an eligible family member as defined herein.

(3) On the date ending the period for which the last premium payment is made for family coverage.

(4) The date of discontinuance of optional group accident insurance under the Insurance Program.

For a family member, in the event an employee dies while enrolled in the family coverage option, optional group accident insurance shall automatically cease on the earliest of the following:

(1) On the date the family member ceases to be an eligible family member as defined in Section F herein.

(2) On the date the surviving spouse remarries.

(3) If the surviving spouse fails to make the required premium contribution for optional group accident insurance when due, the last day of the calendar month immediately preceding the calendar month for which such contribution was due.

(4) On the date of discontinuance of optional group accident insurance under the Insurance Program.

(5) On the expiration of twelve (12) months following the date of the employee's death.

I. Continuation of Insurance

(1) Employee

An employee may continue optional group accident insurance after the last month for which a payroll deduction was made, while on layoff or leave of absence, by paying the required premium contribution to the Insurance Company within thirty-one (31) days of the last month covered by payroll deductions and each month thereafter, in accordance with the following:

a. Layoff

If an employee is laid off, coverage may be continued for the period, not to exceed twelve (12) months, twenty-four (24) months for an employee who has ten (10) or more years of seniority as of the last day worked prior to layoff, equal to that for which the employee may be covered for non-contributory coverage under Article I, Section 3.,E., (1) of this Program, and thereafter for twelve (12) additional months.

b. Leave of Absence

If the employee is on an approved personal leave of absence, coverage may be continued for up to twelve (12) months after the last month for which a payroll deduction was made.

c. Approved Disability Leave of Absence

If an employee is on an approved disability leave of absence, coverage may be continued for the period equal to the lesser of (i) the employee's period of disability or (ii) the employee's seniority.

d. Approved Union Leave of Absence

If the employee is on an approved leave of absence to work for the International or Local Union, coverage may be continued for the duration of the leave.

(2) Retired Employee

A retired employee enrolled as of the last day worked may continue a portion of coverage by paying the required premium contributions. Contributions shall be payable monthly through pension deductions. The required monthly contribution, which is not subject to change during the duration of this Collective Bargaining Agreement, is set forth in the Life Insurance Administration Manual.

If eligible, coverage up to \$150,000 or the amount in force as of the last day worked, whichever is less, may be continued. This amount cannot be increased, but may be decreased or cancelled at any time. Coverage may be changed from retired family

coverage to retired employee coverage, but cannot be changed from retired employee coverage to retired family coverage.

Retired employees and their family members are ineligible for loss of speech and hearing, loss of speech or hearing, loss of thumb and index finger benefits, or benefits described in C., (4), (5), or (6) above.

J. Data

Relevant data will be provided pursuant to Article I, Section 3. I.

Section 6. Group Sickness and Accident Insurance

The group sickness and accident insurance policies referred to in Article I. hereof or any group sickness and accident insurance policy or policies issued in lieu thereof shall, for the period of this Program, include the following:

A. Eligibility and Commencement of Benefits

(1) Eligibility Requirements

In order to be eligible for sickness and accident benefits for either a non-occupational or occupational disability, an employee must meet the following requirements:

(a) become totally and continuously disabled while insured for sickness and accident benefits;

(b) be unable to perform all duties of the Employee's Occupation;

(c) be under the continuous care of a legally licensed Health Care Provider who certifies the employee's total disability;

(d) timely apply for benefits and ensure timely submission of Satisfactory Medical Proof of Disability by their Health Care Provider, as provided in G. Notice of Claim and Proof of Loss;

(e) be compliant with their Health Care Provider's treatment plan for the duration of the disability leave; benefits will not be denied under this paragraph (e) if there are circumstances supporting the employee is compliant.

Claims denied under the provisions of 1.(d) above will be jointly reviewed by the International UAW and the Company and upon agreement by the parties, subject to a physician review. An employee denied benefits pursuant to any Eligibility Requirement may request an appeal of such denial pursuant to Article I, Section 3 H (2).

(2) Commencement of Benefits

Sickness and accident benefits are payable beginning on the first normal working day of accident disability or on the first normal working day after the third calendar day of sickness disability.

(3) Benefit Rate

Sickness and accident benefits are payable as provided below, following the waiting period as

described in (2) above, in weekly benefit amounts determined from the Schedule of Benefits set forth in Article II, Section 9, except that the benefit amount shown in the Schedule of Benefits will be reduced by 25% for any period the employee is otherwise eligible for benefits during any period of disability occurring prior to the day one year of seniority is attained;

(4) Occupational Sickness and Accident Benefits

Benefits shall be made available to insured employees for occupational disability arising out of and in the course of any employment on the same terms as would have applied if the disability had been non-occupational in nature but in a weekly benefit amount equal to the amount by which the non-occupational weekly benefit exceeds the weekly amount of the employee's Workers' Compensation Wage Loss Benefits.

B. Duration of Benefit

The maximum period during which sickness and accident benefits may be payable is 52 weeks.

Upon meeting all Eligibility Requirements as outlined in A above, sickness and accident benefits are payable for the lesser of (1) the period of disability as certified by the employee's Health Care Provider, (2) the Maximum Allowable Period, (3) the last day prior to the date the employee no longer satisfies all the Eligibility Requirements as outlined in A above, (4) the maximum duration for which the employee is eligible for sickness and accident benefits or (5) the date of the employee's death. The Claim Administrator is responsible for determining the Maximum Allowable Period through application of standard disability

industry and medical management tools, which may include a Physician Peer Review. If the employee disputes a denial of benefits for leave exceeding the Maximum Allowable Period, they shall have the right to request an Independent Review through the Claim Administrator. If the employee does not opt to request an Independent Review or disputes the findings of the Independent Review, they shall have the right to request an appeal of such denial of benefits pursuant to Article I, Section 3 H(2). Prior to an appeal, if deemed necessary, the Company or the International Union, UAW may request that a Physician Peer Review be completed.

C. Partial Benefit

Benefits will be paid for a partial week at a daily rate calculated by dividing the weekly benefit payable by five (the number of days in the employee's normal workweek) and multiplying the quotient by the number of normal working days during which the employee was disabled in the workweek for which the partial benefit is being paid. For eligible employees that are on alternative schedules, such as four (4), ten (10) hour days, partial weeks will be calculated in a manner such that it is in proportion to the above calculation.

D. Holiday Pay Offset

Benefits will not be paid to any employee for any day for which such employee is entitled to holiday pay, or pay for the holiday, as provided in the applicable collective bargaining agreement;

E. Reduction of Benefit

Weekly benefits will be reduced by:

(1) any unemployment benefits an employee is eligible to receive under any unemployment compensation law, whether due to employment with the Company or any other employment; and

(2) the weekly equivalent of any Social Security Disability Insurance benefit (primary insurance benefit amount) to which the employee is entitled for the same period under the Federal Social Security Act or any future legislation providing similar benefits, and for purposes of such reduction, the weekly equivalent of benefits paid on a monthly basis is computed by dividing the monthly benefit rate by 4.33; and

(3) all local, state and federal benefits paid due to disability preventing the employee from working; and

(4) Workers' Compensation Wage Loss Benefits, whether due to employment with the Company or any other employment.

F. Successive Disability

A new period of disability will be established when:

(1) A disability absence due to the same or related cause as the last disability absence, and is separated from the previous absence by at least thirty (30) consecutive days of continuous, active on-roll service; or

(2) A disability absence is entirely unrelated to the cause of the previous absence and begins after return to active work with the Company.

G. Notice of Claim and Satisfactory Medical Proof of Disability

In order to qualify for sickness and accident benefits:

(1) the employee's application for benefits must be made with the Claim Administrator within 7 calendar days of the first date of disability; and

(2) initial Satisfactory Medical Proof of Disability must be provided to the Claim Administrator within the first 30 calendar days of disability and any subsequent Satisfactory Medical Proof of Disability must be provided to the Claim Administrator within 30 calendar days from the last day of the period of disability.

Absent extenuating circumstances, the employee is responsible to ensure that both their claim and their Health Care Provider's Satisfactory Medical Proof of Disability are timely submitted to the Claim Administrator. If extenuating circumstances prevent the employee from meeting the required timeframes, the employee may provide proof of the circumstances to the Claim Administrator for review.

H. Waiver

An employee who has one or more years of Seniority may waive irrevocably any right they may have to receive sickness and accident benefits with respect to any period of disability by completing a waiver form furnished by the Claim Administrator for

that purpose, in which case no sickness and accident benefits shall be payable for any period of disability covered by such waiver.

Section 7. Group Reinstated Sickness and Accident Insurance

The group reinstated sickness and accident insurance policies referred to in Article I. hereof or any group reinstated sickness and accident insurance policy or policies issued in lieu thereof shall, for the period of this Program, include the following:

A. Eligibility

To be eligible for benefits, an employee must:

(1) become totally disabled while on a qualifying layoff as defined in the SUB Plan and while insured for group life insurance under Article II. hereof;

(2) immediately prior to his becoming disabled, have been eligible for a Regular Benefit under the SUB Plan or have been ineligible therefore because he was employed by another employer; and

(3) apply for the benefit and furnish the Insurance Company with satisfactory proof of disability;

(4) with respect to each week for which a benefit is claimed, be:

(a) unable to perform all duties of his occupation,

(b) under the care of a Health Care Provider, as described in Article II, Section 6A(1)(c), and

(c) otherwise eligible to receive a benefit under the SUB Plan or if the 1988 SUB Plan is reinstated, has to his credit at least a Credit Unit under the 1988 SUB Plan;

B. Benefit Amount

Weekly reinstated sickness and accident benefits shall be equal in amount to the weekly sickness and accident benefits set forth in Article II., Section 9. hereof;

C. Benefit Commencement:

Benefits start on the first normal working day following the last day for which a Regular Benefit was payable to the employee if he was receiving Regular Benefits immediately prior to his becoming disabled; otherwise on the first normal working day of a qualifying disability;

D. Benefit Reduction or Cessation

(1) The benefit for any week shall be reduced by the amount of any disability benefit he receives for the same week under a plan financed in whole or in part by another employer;

(2) No benefit shall be payable beyond the time:

(a) the employee no longer satisfies the disability requirement except that, if he remains on qualifying layoff under the SUB Plan, benefits shall be payable for remaining days in the same week as defined in the SUB Plan for which he does not receive a Regular Benefit;

(b) the employee receives a sickness and accident or extended disability benefit under this Program, or

(c) the Credit Unit Cancellation Base is below the applicable dollar amount at which a Supplemental Unemployment Benefit is payable in accordance with the employee's seniority as provided under Article II, Section 5(b) of the 1988 SUB Plan. This item (c) applies only if the 1988 SUB Plan is reinstated.

E. Other Provisions

The applicable provisions of Section 6. of this Program, not inconsistent with the provisions of this Section, shall apply to reinstated sickness and accident benefits in the same way as they apply to group sickness and accident benefits under Section 6.

Section 8. Group Extended Disability Insurance

The group extended disability insurance policies referred to in Article I. hereof or any group extended disability insurance policy or policies issued in lieu thereof shall, for the period of this Program, include the following:

A. Eligibility

An employee who is insured for the sickness and accident benefits provided in Section 6. hereof or the reinstated sickness and accident benefits provided in Section 7. hereof, and who, at the date of expiration of the maximum number of weeks for which they are entitled to receive sickness and accident benefits or reinstated sickness and accident benefits and during a continuous period of disability thereafter, is

totally disabled so as to be prevented thereby from engaging in regular employment or occupation with the Company at the plant or plants where they have seniority for remuneration or profit, shall receive monthly extended disability benefits for the period described in F.-J. below (for an employee who waives receipt of sickness and accident benefits or reinstated sickness and accident benefits, the time they waive such benefits shall be deemed the time through which they are entitled to receive them for purposes of this subsection). Additionally, the employee must be compliant with their Health Care Provider's treatment plan for the duration of the disability leave; however, benefits will not be denied for the reason of non-compliance if there are circumstances supporting the employee is compliant.

B. Benefit Amount and Reduction

The monthly extended disability benefit is the applicable amount shown in the Schedule of Benefits in Section 9.

Extended disability benefits are reduced by an amount equal to the monthly equivalent of the total of the following benefits for which the employee is eligible:

(1) All benefits under The Pension Plan or any other pension plan or retirement program then in effect to which the Company or any of its subsidiaries has contributed; and

(2) Workers' Compensation Wage Loss Benefits and permanent partial disability payments for a work-related disability, whether due to employment with the Company or due to other employment, related to the

disability for which benefits under this Section 8 are payable, including such benefits paid in a lump-sum settlement; and

(3) Disability insurance or retirement benefits to which the person is entitled (primary insurance amount) under the Federal Social Security Act or any future legislation providing similar benefits, except retirement benefits reduced because of the age at which received; and

(4) Benefits under any local, state or federal law providing benefits for working time lost because of disability; and

(5) Unemployment benefits an employee is eligible to receive under any unemployment compensation law, whether due to employment with the Company or any other employment.

The Claim Administrator may require each applicant or recipient of extended disability benefits to certify or furnish verification of the amount of their income from sources listed in B. above, and the amount of any extended disability benefit payments in excess of the amount that should have been paid, after reduction for such other benefits, may be deducted from future extended disability benefits.

C. Calculation of Benefit Reduction

In determining the amount by which extended disability benefits are reduced:

(1) the monthly equivalent of benefits paid on a weekly basis is computed by multiplying the weekly benefit rate by 4.33;

(2) lump-sum settlements under workers' compensation laws will result in reductions equal to the monthly equivalent of the amount of the workers' compensation benefit to which the employee would have been entitled under applicable law had there been no lump-sum payment, but not to exceed in total the amount of the settlement; and

(3) the amounts of the reductions under B (1) and B (3) above shall not be increased subsequent to the first day for which extended disability benefits are payable, except that the amounts of such reductions may be increased in connection with any adjustment in the original determination of the amount of such benefits;

D. Presumption of Social Security Disability Insurance and Disability Retirement

Extended disability benefit computations presume eligibility for Social Security disability insurance benefits and disability retirement benefits under the Pension Plan or any other pension plan or retirement program then in effect to which the Company or any of its subsidiaries has contributed, but such presumption of eligibility for disability retirement benefits shall not be made with respect to any extended disability benefit payments due for the twenty-four (24) month period immediately following the date of expiration of the maximum number of weeks for which the employee is entitled to receive sickness and accident benefits or reinstated sickness and accident benefits, and amounts deducted from extended disability benefits on this basis are paid upon presentation of satisfactory evidence that these benefits were applied for and denied; provided, however, that a reduction in extended disability benefits is made in an

amount equal to Social Security disability insurance benefits (primary insurance amount) that would have been payable except for refusal to accept vocational rehabilitation services;

E. Proration

Benefits payable for less than a full calendar month are prorated on the basis of the ratio of calendar days of eligibility to total calendar days in the month;

F. Commencement and Duration of Benefits

(1) Extended disability benefits paid to an eligible applicant shall be for the period commencing the day following the last day of disability included within the period for the maximum number of weekly sickness and accident benefits, or reinstated sickness and accident benefits, including weeks in which such sickness and accident benefits or reinstated sickness and accident benefits were partially or wholly offset because of receipt of other benefits as provided in Article II, Section 6E;

(2) The maximum period during which extended disability benefits may be payable shall be: (a) in the case of an employee who has ten or more years of seniority as of the day on which disability commenced, the number of months commencing with the month in which the date of the expiration of the maximum number of weekly sickness and accident or reinstated sickness and accident benefits occurs and terminating with the end of the month in which the employee attains age 65; and (b) in the case of an employee who has less than ten years of seniority as of the day on which disability commenced, the number of months

by which the employee's full months of seniority at commencement of disability exceeds the period for which they are entitled to receive sickness and accident or reinstated sickness and accident benefits. In any event extended disability benefits shall not be payable beyond the end of the month in which the employee attains age 65, except that if the employee becomes disabled at or after age 63 and subsequently becomes eligible for extended disability benefits, such benefits will be payable in accordance with the following schedule:

<u>Employee's Age at Commencement of Disability</u>	<u>Maximum Duration of Extended Disability Benefits</u>
63 and 0 months but less than 68 and 1 month	12 months
68 and 1 months but less than 68 and 2 months	11 months
68 and 2 months but less than 68 and 3 months	10 months
68 and 3 months but less than 68 and 4 months	9 months
68 and 4 months but less than 68 and 5 months	8 months
68 and 5 months but less than 68 and 6 months	7 months
68 and 6 months and older	6 months

The Claim Administrator is responsible for determining the Maximum Allowable Period through application of standard disability industry and medical management tools, which may include a Physician Peer Review. If the employee disputes a denial of benefits for leave exceeding the Maximum Allowable Period, they shall have the right to request a review of such denial of benefits from the Claim Administrator.

Upon meeting all Eligibility requirements as outlined in A above, extended disability benefits are payable for the lesser of (1) the period of disability as certified by the employee's Health Care Provider, (2) the Maximum Allowable Period as determined by the Claim Administrator, (3) the last calendar day prior to the date the employee no longer satisfies all the Eligibility requirements as outlined in A above, (4) the maximum duration for which the employee is eligible for extended disability benefits, (5) the last calendar day prior to the Company advising an employee with restrictions that they are being reinstated to active roll or (6) the date of the employee's death.

G. Successive Disability

If an employee returns to work with the Company and again becomes disabled by the same or a related cause within 90 (ninety) days of Active On Roll Service, the EDB claim is reopened and benefits are paid at the same rate as were paid prior to the return to work or if the employee engages in regular occupation or employment for remuneration or profit, their satisfying of the disability requirement shall not be deemed to end, but their extended disability benefits shall be suspended for the period of the ineffective return to work or the period the employee engages in such occupation or employment.

H. Benefit Reinstatement

If monthly extended disability benefits are discontinued because the employee no longer satisfies the disability requirement, and within two weeks of such discontinuance and before the employee returns to work, they again become disabled so as to satisfy the disability requirement, monthly extended

disability benefits will be resumed provided the employee meets all Eligibility Requirements and the Maximum Allowable Period has not been exceeded. If the Maximum Allowable Period has been exceeded, the employee and their Health Care Provider must provide new information regarding the employee's current condition and the Claim Administrator will determine whether the Maximum Allowable Period will be amended.

I. Partial Payment

For purposes of applying the maximum period for monthly extended disability benefits, a month in which such benefits are partially or wholly offset by benefit payments from sources listed in B. above, or suspended under G. above or not paid between periods of disability under circumstances described in H. above, are counted as a full month with fractions of the first and last month counted as fractions of a month;

J. Reduction of Benefit Maximum

The cumulative total number of months during any previous periods of eligibility for extended disability benefits, regardless of whether for the same or related disabling condition, reduces the maximum number of monthly benefit payments for which the individual is otherwise eligible under subsection F. (2) above when extended disability benefits again commence;

K. Rehabilitation

There is no ineligibility for extended disability benefits because of work which is determined to be primarily for training under a recognized program of vocational rehabilitation;

L. Proof of Disability

The employee shall furnish proof of continuous care from a legally licensed Health Care Provider who certifies the employee's total disability.

M. Medicare Coverage

An employee eligible for extended disability benefits who is enrolled in the Company's Active health care benefits, is receiving Social Security Disability Insurance benefits and is enrolled in Medicare Part B coverage under the Federal Social Security Act, will while so enrolled receive a monthly special benefit equal to: (1) \$76.20 for months prior to January 1, 2024, (2) the applicable Medicare Part B standard premium for months on or after January 1, 2024. The eligible employee must submit a written request to the Claim Administrator which includes proof of enrollment. Upon the Claim Administrator's confirmation of eligibility, the special benefit payment will begin the following month; and

N. Waiver

An employee may waive irrevocably any right they may have to receive extended disability benefits with respect to any period of disability by completing a waiver form furnished by the Claim Administrator for that purpose, in which case no extended disability benefits shall be payable for any period of disability covered by such waiver.

Section 9. Schedule of Benefits

A. Hourly Employees

(1) Life and Accidental Death and Dismemberment

<u>Base Hourly Rate (1)</u>	<u>Group Life Insurance Amount Before Age 65 (2)</u>	<u>Accidental Death and Dismemberment Benefit Amount (3)</u>
Less than 13.95	31,500	15,750
13.95 but less than 14.30	32,500	16,250
14.30 but less than 14.65	33,000	16,500
14.65 but less than 15.00	34,000	17,000
15.00 but less than 15.35	35,000	17,500
15.35 but less than 15.70	36,000	18,000
15.70 but less than 16.05	36,500	18,250
16.05 but less than 16.40	37,500	18,750
16.40 but less than 16.75	38,000	19,000
16.75 but less than 17.10	38,500	19,250
17.10 but less than 17.45	39,500	19,750
17.45 but less than 17.80	40,500	20,250
17.80 but less than 18.15	41,000	20,500
18.15 but less than 18.50	42,500	21,250
18.50 but less than 18.85	43,000	21,500
18.85 but less than 19.20	44,000	22,000
19.20 but less than 19.55	44,500	22,250
19.55 but less than 19.90	45,500	22,750
19.90 but less than 20.25	46,500	23,250
20.25 but less than 20.60	47,000	23,500
20.60 but less than 20.95	47,500	23,750
20.95 but less than 21.30	48,500	24,250
21.30 but less than 21.65	49,000	24,500
21.65 but less than 22.00	50,000	25,000
22.00 but less than 22.35	50,500	25,250
22.35 but less than 22.70	51,500	25,750
22.70 but less than 23.05	52,500	26,250
23.05 but less than 23.40	53,000	26,500
23.40 but less than 23.75	54,000	27,000
23.75 but less than 24.10	54,500	27,250
24.10 but less than 24.45	55,500	27,750
24.45 but less than 24.80	56,500	28,250
24.80 but less than 25.15	57,000	28,500

25.15 but less than 25.50	58,000	29,000
25.50 but less than 25.85	58,500	29,250
25.85 but less than 26.20	59,500	29,750
26.20 but less than 26.55	60,500	30,250
26.55 but less than 26.90	61,000	30,500
26.90 but less than 27.25	62,000	31,000
27.25 but less than 27.60	62,500	31,250
27.60 but less than 27.95	63,500	31,750
27.95 but less than 28.30	64,500	32,250
28.30 but less than 28.65	65,000	32,500
28.65 but less than 29.00	66,000	33,000
29.00 but less than 29.35	67,000	33,500
29.35 but less than 29.70	68,000	34,000
29.70 but less than 30.05	68,500	34,250
30.05 but less than 30.40	69,500	34,750
30.40 but less than 30.75	70,000	35,000
30.75 but less than 31.10	71,000	35,500
31.10 but less than 31.45	72,000	36,000
31.45 but less than 31.80	72,500	36,250
31.80 but less than 32.15	73,500	36,750
32.15 but less than 32.50	74,000	37,000
32.50 but less than 32.85	75,000	37,500
32.85 but less than 33.20	75,500	37,750
33.20 but less than 33.55	76,500	38,250
33.55 but less than 33.90	77,000	38,500
33.90 but less than 34.25	78,000	39,000
34.25 but less than 34.60	79,000	39,500
34.60 but less than 34.95	79,500	39,750
34.95 but less than 35.30	80,500	40,250
35.30 but less than 35.65	81,000	40,500
35.65 but less than 36.00	82,000	41,000
36.00 but less than 36.35	83,000	41,500
36.35 but less than 36.70	83,500	41,750
36.70 but less than 37.05	84,500	42,250
37.05 but less than 37.40	85,000	42,500
37.40 but less than 37.75	86,000	43,000
37.75 but less than 38.10	86,500	43,250
38.10 but less than 38.45	87,500	43,750
38.45 but less than 38.80	88,500	44,250
38.80 but less than 39.15	89,000	44,500
39.15 but less than 39.50	90,000	45,000
39.50 but less than 39.85	91,000	45,500
39.85 but less than 40.20	91,500	45,750

40.20 but less than 40.55	92,500	46,250
40.55 but less than 40.90	93,000	46,500
40.90 but less than 41.25	94,000	47,000
41.25 but less than 41.60	94,500	47,250
41.60 but less than 41.95	95,500	47,750
41.95 but less than 42.30	96,500	48,250
42.30 but less than 42.65	97,000	48,500
42.65 but less than 43.00	98,000	49,000
43.00 but less than 43.35	98,500	49,250
43.35 but less than 43.70	99,500	49,750
43.70 but less than 44.05	100,500	50,250
44.05 but less than 44.40	101,000	50,500
44.40 but less than 44.75	102,000	51,000
44.75 but less than 45.10	102,500	51,250
45.10 but less than 45.45	103,500	51,750
45.45 but less than 45.80	104,500	52,250
45.80 but less than 46.15	105,000	52,500
46.15 but less than 46.50	106,000	53,000
46.50 but less than 46.85	106,500	53,250
46.85 but less than 47.20	107,500	53,750
47.20 but less than 47.55	108,500	54,250
47.55 but less than 47.90	109,000	54,500
47.90 but less than 48.25	110,000	55,000
48.25 but less than 48.60	110,500	55,250
48.60 but less than 48.95	111,500	55,750
48.95 but less than 49.30	112,500	56,250
49.30 but less than 49.65	113,000	56,500
49.65 but less than 50.00	114,000	57,000
50.00 but less than 50.35	114,500	57,250
50.35 and above	115,500	57,750

(1) “Base Hourly Rate” shall exclude overtime additions to straight-time pay, shift differentials, cost-of-living allowances, payments-in-lieu of vacation, and all other extra compensation. For an employee working on a piece-work or incentive-method-of-pay basis, the “Base Hourly Rate” as of any given time shall be the employee’s average earned hourly rate for the four pay periods (in which the employee worked full weeks) immediately preceding such given time.

(2) After age 65 the amount shown will be reduced as provided in Article II., Section 1

(3) Three times the scheduled amount may be payable for an occupational-related death (as defined in Section 4. B.)

(2) Sickness and Accident and Extended Disability Benefits

<u>Base Hourly Rate (1)</u>	<u>Weekly Sickness & Accident Benefit Amount</u>	<u>Monthly Extended Benefit Schedule I</u>	<u>Disability Amount (2) Schedule II</u>
Less than 13.95	330	1,220	1,340
13.95 but less than 14.30	340	1,250	1,370
14.30 but less than 14.65	345	1,280	1,405
14.65 but less than 15.00	355	1,310	1,440
15.00 but less than 15.35	365	1,340	1,475
15.35 but less than 15.70	375	1,370	1,505
15.70 but less than 16.05	380	1,405	1,540
16.05 but less than 16.40	390	1,435	1,575
16.40 but less than 16.75	400	1,465	1,610
16.75 but less than 17.10	405	1,495	1,640
17.10 but less than 17.45	415	1,525	1,675
17.45 but less than 17.80	425	1,560	1,710
17.80 but less than 18.15	430	1,590	1,745
18.15 but less than 18.50	440	1,620	1,780
18.50 but less than 18.85	450	1,650	1,810
18.85 but less than 19.20	455	1,680	1,845
19.20 but less than 19.55	465	1,710	1,880
19.55 but less than 19.90	475	1,745	1,915
19.90 but less than 20.25	480	1,775	1,950
20.25 but less than 20.60	490	1,805	1,980
20.60 but less than 20.95	500	1,835	2,015
20.95 but less than 21.30	505	1,865	2,050
21.30 but less than 21.65	515	1,900	2,085
21.65 but less than 22.00	525	1,930	2,120
22.00 but less than 22.35	530	1,960	2,150
22.35 but less than 22.70	540	1,990	2,185
22.70 but less than 23.05	550	2,020	2,220
23.05 but less than 23.40	555	2,055	2,255
23.40 but less than 23.75	565	2,085	2,290

23.75 but less than 24.10	575	2,115	2,320
24.10 but less than 24.45	585	2,145	2,355
24.45 but less than 24.80	590	2,175	2,390
24.80 but less than 25.15	600	2,205	2,425
25.15 but less than 25.50	610	2,240	2,460
25.50 but less than 25.85	615	2,270	2,490
25.85 but less than 26.20	625	2,300	2,525
26.20 but less than 26.55	635	2,330	2,560
26.55 but less than 26.90	640	2,360	2,595
26.90 but less than 27.25	650	2,395	2,630
27.25 but less than 27.60	660	2,425	2,660
27.60 but less than 27.95	665	2,455	2,695
27.95 but less than 28.30	675	2,485	2,730
28.30 but less than 28.65	685	2,515	2,765
28.65 but less than 29.00	690	2,550	2,795
29.00 but less than 29.35	700	2,580	2,830
29.35 but less than 29.70	710	2,610	2,865
29.70 but less than 30.05	715	2,640	2,900
30.05 but less than 30.40	725	2,670	2,935
30.40 but less than 30.75	735	2,700	2,965
30.75 but less than 31.10	740	2,735	3,000
31.10 but less than 31.45	750	2,765	3,035
31.45 but less than 31.80	760	2,795	3,070
31.80 but less than 32.15	765	2,825	3,105
32.15 but less than 32.50	775	2,855	3,135
32.50 but less than 32.85	785	2,890	3,170
32.85 but less than 33.20	795	2,920	3,205
33.20 but less than 33.55	800	2,950	3,240
33.55 but less than 33.90	810	2,980	3,275
33.90 but less than 34.25	820	3,010	3,305
34.25 but less than 34.60	825	3,045	3,340
34.60 but less than 34.95	835	3,075	3,375
34.95 but less than 35.30	845	3,105	3,410
35.30 but less than 35.65	850	3,135	3,445
35.65 but less than 36.00	860	3,165	3,475
36.00 but less than 36.35	870	3,195	3,510
36.35 but less than 36.70	875	3,230	3,545
36.70 but less than 37.05	885	3,260	3,580
37.05 but less than 37.40	895	3,290	3,615
37.40 but less than 37.75	900	3,320	3,645
37.75 but less than 38.10	910	3,350	3,680
38.10 but less than 38.45	920	3,385	3,715
38.45 but less than 38.80	925	3,415	3,750
38.80 but less than 39.15	935	3,445	3,785
39.15 but less than 39.50	945	3,475	3,815

39.50 but less than 39.85	950	3,505	3,850
39.85 but less than 40.20	960	3,535	3,880
40.20 but less than 40.55	970	3,565	3,915
40.55 but less than 40.90	975	3,600	3,950
40.90 but less than 41.25	985	3,630	3,985
41.25 but less than 41.60	995	3,660	4,020
41.60 but less than 41.95	1,000	3,690	4,050
41.95 but less than 42.30	1,010	3,720	4,085
42.30 but less than 42.65	1,020	3,750	4,120
42.65 but less than 43.00	1,030	3,785	4,155
43.00 but less than 43.35	1,035	3,815	4,190
43.35 but less than 43.70	1,045	3,845	4,220
43.70 but less than 44.05	1,055	3,875	4,255
44.05 but less than 44.40	1,060	3,905	4,290
44.40 but less than 44.75	1,070	3,935	4,325
44.75 but less than 45.10	1,080	3,970	4,355
45.10 but less than 45.45	1,085	4,000	4,390
45.45 but less than 45.80	1,095	4,030	4,425
45.80 but less than 46.15	1,105	4,060	4,460
46.15 but less than 46.50	1,110	4,090	4,495
46.50 but less than 46.85	1,120	4,120	4,525
46.85 but less than 47.20	1,130	4,155	4,560
47.20 but less than 47.55	1,135	4,185	4,595
47.55 but less than 47.90	1,145	4,215	4,630
47.90 but less than 48.25	1,155	4,245	4,665
48.25 but less than 48.60	1,160	4,275	4,695
48.60 but less than 48.95	1,170	4,310	4,730
48.95 but less than 49.30	1,180	4,340	4,765
49.30 but less than 49.65	1,185	4,370	4,800
49.65 but less than 50.00	1,195	4,400	4,830
50.00 but less than 50.35	1,205	4,430	4,865
50.35 and above	1,215	4,465	4,900

(1) “Base Hourly Rate” shall exclude overtime additions to straight-time pay, shift differentials, cost-of-living allowances, payments-in-lieu of vacation, and all other extra compensation. For an employee working on a piece-work or incentive-method-of-pay basis, the “Base Hourly Rate” as of any given time shall be the employee’s average earned hourly rate for the four pay periods (in which the employee worked full weeks) immediately preceding such given time.

(2) Schedule II applies to eligible employees who on their last day worked preceding a continuous period of disability have ten or more years of credited service under the Pension Plan. Schedule I applies to all other employees eligible for Extended Disability Benefits.

B. Salary Employees

(1) Life and Accidental Death and Dismemberment Benefits

<u>Base Weekly Salary (1)</u>	<u>Group Life Insurance Amount Before Age 65 (2)</u>	<u>Accidental Death and Dismemberment Benefit Amount (3)</u>
Less than 562.35	47,000	23,500
562.35 but less than 573.85	48,000	24,000
573.85 but less than 585.35	49,000	24,500
585.35 but less than 596.85	50,000	25,000
596.85 but less than 608.35	51,000	25,500
608.35 but less than 619.85	52,000	26,000
619.85 but less than 631.35	53,000	26,500
631.35 but less than 642.85	54,000	27,000
642.85 but less than 654.35	55,000	27,500
654.35 but less than 665.85	56,000	28,000
665.85 but less than 677.35	57,000	28,500
677.35 but less than 688.85	58,000	29,000
688.85 but less than 700.35	59,000	29,500
700.35 but less than 711.85	60,000	30,000
711.85 but less than 723.35	61,000	30,500
723.35 but less than 734.85	62,000	31,000
734.85 but less than 746.35	63,000	31,500
746.35 but less than 757.85	64,000	32,000
757.85 but less than 769.35	65,000	32,500
769.35 but less than 780.85	66,000	33,000
780.85 but less than 792.35	67,000	33,500
792.35 but less than 803.85	68,000	34,000
803.85 but less than 815.35	69,000	34,500
815.35 but less than 826.85	70,000	35,000
826.85 but less than 838.35	71,000	35,500
838.35 but less than 849.85	72,000	36,000
849.85 but less than 861.35	73,000	36,500
861.35 but less than 872.85	74,000	37,000
872.85 but less than 884.35	75,000	37,500
884.35 but less than 895.85	76,000	38,000

895.85 but less than 907.35	77,000	38,500
907.35 but less than 918.85	78,000	39,000
918.85 but less than 930.35	79,000	39,500
930.35 but less than 941.85	80,000	40,000
941.85 but less than 953.35	81,000	40,500
953.35 but less than 964.85	82,000	41,000
964.85 but less than 976.35	83,000	41,500
976.35 but less than 987.85	84,000	42,000
987.85 but less than 999.35	85,000	42,500
999.35 but less than 1,010.85	86,000	43,000
1,010.85 but less than 1,022.35	87,000	43,500
1,022.35 but less than 1,033.85	88,000	44,000
1,033.85 but less than 1,045.35	89,000	44,500
1,045.35 but less than 1,056.85	90,000	45,000
1,056.85 but less than 1,068.35	91,000	45,500
1,068.35 but less than 1,079.85	92,000	46,000
1,079.85 but less than 1,091.35	93,000	46,500
1,091.35 but less than 1,102.85	94,000	47,000
1,102.85 but less than 1,114.35	95,000	47,500
1,114.35 but less than 1,125.85	95,000	47,500
1,125.85 but less than 1,137.35	96,000	48,000
1,137.35 but less than 1,148.85	97,000	48,500
1,148.85 but less than 1,160.35	98,000	49,000
1,160.35 but less than 1,171.85	99,000	49,500
1,171.85 but less than 1,183.35	100,000	50,000
1,183.35 but less than 1,194.85	101,000	50,500
1,194.85 but less than 1,206.35	102,000	51,000
1,206.35 but less than 1,217.85	103,000	51,500
1,217.85 but less than 1,229.35	104,000	52,000
1,229.35 but less than 1,240.85	105,000	52,500
1,240.85 but less than 1,252.35	106,000	53,000
1,252.35 but less than 1,263.85	107,000	53,500
1,263.85 but less than 1,275.35	108,000	54,000
1,275.35 but less than 1,286.85	109,000	54,500
1,286.85 but less than 1,298.85	110,000	55,000
1,298.85 but less than 1,309.85	111,000	55,500
1,309.85 but less than 1,321.35	112,000	56,000
1,321.35 but less than 1,332.85	113,000	56,500
1,332.85 but less than 1,344.35	114,000	57,000
1,344.35 but less than 1,355.85	115,000	57,500
1,355.85 but less than 1,367.35	116,000	58,000
1,367.35 but less than 1,378.85	117,000	58,500
1,378.85 but less than 1,390.35	118,000	59,000
1,390.35 but less than 1,401.85	119,000	59,500
1,401.85 but less than 1,413.35	120,000	60,000
1,413.35 but less than 1,424.85	121,000	60,500

1,424.85 but less than 1,436.35	122,000	61,000
1,436.35 but less than 1,447.85	123,000	61,500
1,447.85 but less than 1,459.35	124,000	62,000
1,459.35 but less than 1,470.85	125,000	62,500
1,470.85 but less than 1,482.35	126,000	63,000
1,482.35 but less than 1,493.85	127,000	63,500
1,493.85 but less than 1,505.35	128,000	64,000
1,505.35 but less than 1,516.85	129,000	64,500
1,516.85 but less than 1,528.35	130,000	65,000
1,528.35 but less than 1,539.85	131,000	65,500
1,539.85 but less than 1,551.35	132,000	66,000
1,551.35 but less than 1,562.85	133,000	66,500
1,562.85 but less than 1,574.35	134,000	67,000
1,574.35 but less than 1,585.85	135,000	67,500
1,585.85 but less than 1,597.35	136,000	68,000
1,597.35 but less than 1,608.85	137,000	68,500
1,608.85 but less than 1,620.35	138,000	69,000
1,620.35 but less than 1,631.85	139,000	69,500
1,631.85 but less than 1,643.35	140,000	70,000
1,643.35 but less than 1,654.85	141,000	70,500
1,654.85 but less than 1,666.35	142,000	71,000
1,666.35 but less than 1,677.85	143,000	71,500
1,677.85 but less than 1,689.35	144,000	72,000
1,689.35 but less than 1,700.85	145,000	72,500
1,700.85 but less than 1,712.35	146,000	73,000
1,712.35 but less than 1,723.85	147,000	73,500
1,723.85 but less than 1,735.35	148,000	74,000
1,735.35 but less than 1,746.85	149,000	74,500
1,746.85 but less than 1,758.35	150,000	75,000
1,758.35 but less than 1,769.85	151,000	75,500
1,769.85 but less than 1,781.35	152,000	76,000
1,781.35 but less than 1,792.85	153,000	76,500
1,792.85 but less than 1,804.35	154,000	77,000
1,804.35 but less than 1,815.85	155,000	77,500
1,815.85 but less than 1,827.35	156,000	78,000
1,827.35 but less than 1,838.85	157,000	78,500
1,838.85 but less than 1,850.35	158,000	79,000
1,850.35 but less than 1,861.85	159,000	79,500
1,861.85 but less than 1,873.35	160,000	80,000
1,873.35 but less than 1,884.85	161,000	80,500
1,884.85 but less than 1,896.35	162,000	81,000
1,896.35 but less than 1,907.85	163,000	81,500
1,907.85 but less than 1,919.35	164,000	82,000
1,919.35 but less than 1,930.85	165,000	82,500
1,930.85 but less than 1,942.35	166,000	83,000
1,942.35 but less than 1,953.85	167,000	83,500

1,953.85 but less than 1,965.35	168,000	84,000
1,965.35 but less than 1,976.85	169,000	84,500
1,976.85 but less than 1,988.35	170,000	85,000
1,988.35 but less than 1,999.85	171,000	85,500
1,999.85 but less than 2,011.35	172,000	86,000
2,011.35 but less than 2,022.85	173,000	86,500
2,022.85 but less than 2,034.35	174,000	87,000
2,034.35 but less than 2,045.85	175,000	87,500
2,045.85 but less than 2,057.35	176,000	88,000
2,057.35 but less than 2,068.85	177,000	88,500
2,068.85 but less than 2,080.35	178,000	89,000
2,080.35 but less than 2,090.85	179,000	89,500
2,091.85 but less than 2,103.35	180,000	90,000
2,103.35 but less than 2,114.85	181,000	90,500
2,114.85 but less than 2,126.35	182,000	91,000
2,126.35 but less than 2,137.85	183,000	91,500
2,137.85 but less than 2,149.35	184,000	92,000
2,149.35 but less than 2,160.85	185,000	92,500
2,160.85 but less than 2,172.35	186,000	93,000
2,172.35 but less than 2,183.85	187,000	93,500
2,183.85 but less than 2,195.35	188,000	94,000
2,195.35 but less than 2,206.85	189,000	94,500
2,206.85 but less than 2,218.35	190,000	95,000
2,218.35 but less than 2,229.85	191,000	95,500
2,229.85 but less than 2,241.35	192,000	96,000
2,241.35 but less than 2,252.85	193,000	96,500
2,252.85 but less than 2,264.35	194,000	97,000
2,264.35 but less than 2,275.85	195,000	97,500
2,275.85 but less than 2,287.35	196,000	98,000
2,287.35 but less than 2,298.85	197,000	98,500
2,298.85 and above	198,000	99,000

(1) “Base Weekly Salary” shall exclude overtime additions to straight-time pay, shift differentials, cost-of-living allowances, and all other extra compensation.

(2) After age 65 the amount shown will be reduced as provided in Article II, Section 1.

(3) Three times the scheduled amount may be payable for an occupational-related death (as defined in Section 4. B).

(2) Sickness and Accident and Extended Disability Benefits

<u>Base Weekly Salary (1)</u>	<u>Weekly Sickness & Accident Benefit Amount</u>	<u>Monthly Extended Disability Benefit Amount Schedule I</u>	<u>Monthly Extended Disability Benefit Amount Schedule II (2)</u>
Less than 562.35	339	1,230	1,350
562.35 but less than 573.85	346	1,255	1,380
573.85 but less than 585.35	353	1,280	1,405
585.35 but less than 596.85	360	1,305	1,435
596.85 but less than 608.35	367	1,330	1,460
608.35 but less than 619.85	374	1,355	1,490
619.85 but less than 631.35	381	1,385	1,520
631.35 but less than 642.85	388	1,410	1,545
642.85 but less than 654.35	395	1,435	1,575
654.35 but less than 665.85	402	1,460	1,600
665.85 but less than 677.35	409	1,485	1,630
677.35 but less than 688.85	416	1,510	1,660
688.85 but less than 700.35	423	1,535	1,685
700.35 but less than 711.85	430	1,560	1,715
711.85 but less than 723.35	437	1,585	1,740
723.35 but less than 734.85	444	1,610	1,770
734.85 but less than 746.35	451	1,635	1,795
746.35 but less than 757.85	458	1,660	1,825
757.85 but less than 769.35	465	1,690	1,855
769.35 but less than 780.85	472	1,715	1,880
780.85 but less than 792.35	479	1,740	1,910
792.35 but less than 803.85	486	1,765	1,935
803.85 but less than 815.35	493	1,790	1,965
815.35 but less than 826.85	500	1,815	1,995
826.85 but less than 838.35	507	1,840	2,020
838.35 but less than 849.85	514	1,865	2,050
849.85 but less than 861.35	521	1,890	2,075
861.35 but less than 872.85	528	1,915	2,105
872.85 but less than 884.35	535	1,940	2,130
884.35 but less than 895.85	542	1,965	2,160
895.85 but less than 907.35	549	1,995	2,190
907.35 but less than 918.85	556	2,020	2,215
918.85 but less than 930.35	563	2,045	2,245
930.35 but less than 941.85	570	2,070	2,270
941.85 but less than 953.35	577	2,095	2,300
953.35 but less than 964.85	584	2,120	2,325
964.85 but less than 976.35	591	2,145	2,355

976.35 but less than 987.85	598	2,170	2,385
987.85 but less than 999.35	605	2,195	2,410
999.35 but less than 1,010.85	612	2,220	2,440
1,010.85 but less than 1,022.35	619	2,245	2,465
1,022.35 but less than 1,033.85	626	2,270	2,495
1,033.85 but less than 1,045.35	633	2,300	2,525
1,045.35 but less than 1,056.85	640	2,325	2,550
1,056.85 but less than 1,068.35	647	2,350	2,580
1,068.35 but less than 1,079.85	654	2,375	2,605
1,079.85 but less than 1,091.35	661	2,400	2,635
1,091.35 but less than 1,102.85	668	2,425	2,660
1,102.85 but less than 1,114.35	675	2,450	2,690
1,114.35 but less than 1,125.85	682	2,475	2,720
1,125.85 but less than 1,137.35	689	2,500	2,745
1,137.35 but less than 1,148.85	696	2,525	2,775
1,148.85 but less than 1,160.35	703	2,550	2,800
1,160.35 but less than 1,171.85	710	2,575	2,830
1,171.85 but less than 1,183.35	717	2,600	2,860
1,183.35 but less than 1,194.85	724	2,630	2,885
1,194.85 but less than 1,206.35	731	2,655	2,915
1,206.35 but less than 1,217.85	738	2,680	2,940
1,217.85 but less than 1,229.35	745	2,705	2,970
1,229.35 but less than 1,240.85	752	2,730	2,995
1,240.85 but less than 1,252.35	759	2,755	3,025
1,252.35 but less than 1,263.85	766	2,780	3,055
1,263.85 but less than 1,275.35	773	2,805	3,080
1,275.35 but less than 1,286.85	780	2,830	3,110
1,286.85 but less than 1,298.35	787	2,855	3,135
1,298.35 but less than 1,309.85	794	2,880	3,165
1,309.85 but less than 1,321.35	801	2,905	3,195
1,321.35 but less than 1,332.85	808	2,935	3,220
1,332.85 but less than 1,344.35	815	2,960	3,250
1,344.35 but less than 1,355.85	822	2,985	3,275
1,355.85 but less than 1,367.35	829	3,010	3,305
1,367.35 but less than 1,378.85	836	3,035	3,330
1,378.85 but less than 1,390.35	843	3,060	3,360
1,390.35 but less than 1,401.85	850	3,085	3,390
1,401.85 but less than 1,413.35	857	3,110	3,415
1,413.35 but less than 1,424.85	864	3,135	3,445
1,424.85 but less than 1,436.35	871	3,160	3,470
1,436.35 but less than 1,447.85	878	3,185	3,500
1,447.85 but less than 1,459.35	885	3,210	3,525
1,459.35 but less than 1,470.85	892	3,240	3,555
1,470.85 but less than 1,482.35	899	3,265	3,585
1,482.35 but less than 1,493.85	906	3,290	3,610
1,493.85 but less than 1,505.35	913	3,315	3,640

1,505.35 but less than 1,516.85	920	3,340	3,665
1,516.85 but less than 1,528.35	927	3,365	3,695
1,528.35 but less than 1,539.85	934	3,390	3,725
1,539.85 but less than 1,551.35	941	3,415	3,750
1,551.35 but less than 1,562.85	948	3,440	3,780
1,562.85 but less than 1,574.35	955	3,465	3,805
1,574.35 but less than 1,585.85	962	3,490	3,835
1,585.85 but less than 1,597.35	969	3,515	3,860
1,597.35 but less than 1,608.85	976	3,545	3,890
1,608.85 but less than 1,620.35	983	3,570	3,920
1,620.35 but less than 1,631.85	990	3,595	3,945
1,631.85 but less than 1,643.35	997	3,620	3,975
1,643.35 but less than 1,654.85	1,004	3,645	4,000
1,654.85 but less than 1,666.35	1,011	3,670	4,030
1,666.35 but less than 1,677.85	1,018	3,690	4,060
1,677.85 but less than 1,689.35	1,025	3,720	4,085
1,689.35 but less than 1,700.85	1,032	3,745	4,115
1,700.85 but less than 1,712.35	1,039	3,770	4,140
1,712.35 but less than 1,723.85	1,046	3,795	4,165
1,723.85 but less than 1,735.35	1,053	3,820	4,195
1,735.35 but less than 1,746.85	1,060	3,845	4,220
1,746.85 but less than 1,758.35	1,067	3,870	4,250
1,758.35 but less than 1,769.85	1,074	3,895	4,280
1,769.85 but less than 1,781.35	1,081	3,920	4,305
1,781.35 but less than 1,792.85	1,088	3,945	4,335
1,792.85 but less than 1,804.35	1,095	3,970	4,360
1,804.35 but less than 1,815.85	1,102	3,995	4,390
1,815.85 but less than 1,827.35	1,109	4,020	4,415
1,827.35 but less than 1,838.85	1,116	4,050	4,445
1,838.85 but less than 1,850.35	1,123	4,075	4,475
1,850.35 but less than 1,861.85	1,130	4,100	4,500
1,861.85 but less than 1,873.35	1,137	4,125	4,530
1,873.35 but less than 1,884.85	1,144	4,150	4,555
1,884.85 but less than 1,896.35	1,151	4,175	4,585
1,896.35 but less than 1,907.85	1,158	4,200	4,610
1,907.85 but less than 1,919.35	1,165	4,225	4,640
1,919.35 but less than 1,930.85	1,172	4,250	4,670
1,930.85 but less than 1,942.35	1,179	4,275	4,695
1,942.35 but less than 1,953.85	1,186	4,300	4,725
1,953.85 but less than 1,965.35	1,193	4,325	4,750
1,965.35 but less than 1,976.85	1,200	4,350	4,780
1,976.85 but less than 1,988.35	1,207	4,380	4,805
1,988.35 but less than 1,999.85	1,214	4,405	4,835
1,999.85 but less than 2,011.35	1,221	4,430	4,865
2,011.35 but less than 2,022.85	1,228	4,455	4,890
2,022.85 but less than 2,034.35	1,235	4,480	4,920

2,034.35 but less than 2,045.85	1,242	4,505	4,945
2,045.85 but less than 2,057.35	1,249	4,530	4,975
2,057.35 but less than 2,068.85	1,256	4,555	5,000
2,068.85 but less than 2,080.35	1,263	4,580	5,030
2,080.35 but less than 2,091.85	1,270	4,605	5,060
2,091.85 but less than 2,103.35	1,277	4,630	5,085
2,103.35 but less than 2,114.85	1,284	4,655	5,115
2,114.85 but less than 2,126.35	1,291	4,685	5,140
2,126.35 but less than 2,137.85	1,298	4,710	5,170
2,137.85 but less than 2,149.35	1,305	4,735	5,200
2,149.35 but less than 2,160.85	1,312	4,760	5,225
2,160.85 but less than 2,172.35	1,319	4,785	5,255
2,172.35 but less than 2,183.85	1,326	4,810	5,280
2,183.85 but less than 2,195.35	1,333	4,835	5,310
2,195.35 but less than 2,206.85	1,340	4,860	5,335
2,206.85 but less than 2,218.35	1,347	4,885	5,365
2,218.35 but less than 2,229.85	1,354	4,910	5,395
2,229.85 but less than 2,241.35	1,361	4,935	5,420
2,241.35 but less than 2,252.85	1,368	4,960	5,450
2,252.85 but less than 2,264.35	1,375	4,985	5,475
2,264.35 but less than 2,275.85	1,382	5,015	5,505
2,275.85 but less than 2,287.35	1,389	5,040	5,530
2,287.35 but less than 2,298.85	1,396	5,065	5,560
2,298.85 and above	1,403	5,090	5,590

(1) “Base Weekly Salary” shall exclude overtime additions to straight-time pay, shift differentials, cost-of-living allowances, and all other extra compensation.

(2) Schedule II applies to eligible employees who on their last day worked preceding a continuous period of disability have ten or more years of credited service under the Pension Plan. Schedule I applies to all other employees eligible for Extended Disability Benefits.

Section 10. Definitions

The following definitions apply to Sickness and Accident Insurance, Reinstated Sickness and Accident Insurance and Extended Disability Insurance as outlined in Sections 6, 7, 8, and 9 herein:

(1) “Active On Roll Service” means a continuous period during which the employee is actively working or available for work. Individual casual absences, vacation, PAA, holidays and periods of temporary layoff do not break a period of Active On Roll Service.

(2) “Claim Administrator” means the third-party administrator responsible for administering the benefits provided under Sections 6, 7 and 8, or if the benefits provided under Sections 6, 7 and 8 are fully insured and the insurer administers the claims, it means the insurance company.

(3) “Employee’s Occupation” means any work within the employee’s work location for which the employee has the required qualifications to perform.

(4) “Health Care Provider” means:

(a) For non-mental health or substance use disorder conditions:

(i) a medical or osteopathic doctor, physician or surgeon; or

(ii) a nurse practitioner; or

(iii) a physician assistant; or

(iv) a podiatrist; or

(v) an optometrist; or

(vi) a dentist; or

(vii) a certified nurse midwife;

(b) For mental health or substance use disorder conditions:

(i) a psychiatrist; or

(ii) a medical or osteopathic doctor board certified in addiction medicine; or

- (iii) a psychiatric nurse practitioner; or
- (iv) a psychiatric physician assistant; or
- (v) a master degreed licensed professional counselor (LPC); or
- (vi) a master degreed licensed clinical social worker (LCSW); or
- (vii) a master degreed licensed master's social worker (LMSW); or
- (viii) a master degreed substance abuse counselor; or
- (ix) a doctorate level psychologist; or
- (x) for up to the first 60 days of the initial period of disability or the first 60 days following an initial mental health or substance use disorder diagnosis or the first 30 days of a reopened claim, a medical or osteopathic doctor, nurse practitioner or physician assistant as outlined in (a)(i), (a)(ii) or (a)(iii) above.

In all cases, the Health Care Provider must be legally licensed by the state in which they practice and must be providing care and treatment within the scope of their license.

(5) "Independent Review" means a review of a disputed claim denial or termination when the Claim Administrator determines medical information submitted does not meet the criteria for Satisfactory Medical Proof of Disability or if the leave is approved, the leave extends beyond the Maximum Allowable Period. The review is performed by a Claim Administrator colleague not involved with the initial claim decision.

(6) "Maximum Allowable Period" means the period of approved disability leave as determined by the Claim Administrator.

(7) “Physician Peer Review” means a comprehensive review of medical records by an independent, qualified reviewer, including contact with the employee’s Health Care Provider as needed. The Physician Peer Reviewer may provide an opinion regarding return to work, restrictions and limitations and standards of care.

(8) “Satisfactory Medical Proof of Disability” means certification from a Health Care Provider received timely pursuant to the Eligibility Requirements which applies evidence-based medicine, provides a duration that meets accepted disability duration guidelines, supports the employee is unable to perform all duties of the Employee’s Occupation and addresses the nature of disability, subjective and objective findings, treatment plan, why the condition is disabling and prognosis.

(9) “Seniority” means the employee’s Corporate Service Date.

(10) “Standard Disability Industry and Medical Management Tools” means claims management tools that are used by claim administrators and insurance companies to manage disability benefit claims and include items such as:

(a) Nurse case manager reviews

(b) Nurse case manager contact with employees and health care providers

(c) Duration guidelines based upon diagnosis or procedure, such as ODG

(d) Physician Peer Reviews

(11) “Workers’ Compensation Wage Loss Benefits” means, regardless of the specific term used by the applicable state, benefits paid pursuant to a workers’ compensation statute for compensation for time lost from work due to total or partial disability, loss of earning capacity, loss of vocation, displaced worker benefits, etc. due to work restrictions, benefits paid for loss of wages while participating in a vocational training program, permanent partial disability benefits related to the disability for which sickness and accident, reinstated sickness and accident or extended disability benefits are being paid or any other benefit paid pursuant to a workers’ compensation statute that is not Workers’ Compensation Other Benefits.

(12) “Workers’ Compensation Other Benefits” means, regardless of the specific term used by the applicable state:

(a) Loss/Loss of Use: benefits paid pursuant to a state workers’ compensation statute for scheduled loss, specific loss, permanent partial disability or permanent partial impairment to compensate for loss by amputation or partial or 100% loss of use for a work-related disability unrelated to the disability for which sickness and accident, reinstated sickness and accident or extended disability benefits are being paid

(b) Vocational Services: fees paid to vocational counselors, training programs or schools

(c) Medical: payment of fees and services related to the delivery of health care

(d) Expenses: payment of expenses incurred by the employee such as mileage reimbursement, home health care and lost wages due to attendance at an Independent Medical Exam requested by the Company

ARTICLE III. Group Hospital, Surgical, Medical, Drug, Dental, Vision and Hearing Aid Coverage

Section 1. Eligibility For Coverage

A. Employee

The Company will make suitable arrangements for eligible employees to participate in the hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverage, referred to in this Article III.

The Company will contribute monthly for each such employee who elects such hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverage the applicable group premium or subscription charges for coverage for (a) self (b) 2 party or (c) family; provided, however, that the Company's contributions toward an alternative plan will not exceed the rates for the Standard Care Network option unless the Company at its option waives this limitation in whole or in part. Where permitted under the policy or contract under which such employee is covered, the Company may permit such employee to elect hospital, surgical, medical, prescription drug and hearing aid (but not dental or vision) coverage for sponsored dependents. Such employee shall pay the entire cost of coverage for sponsored dependents.

B. Surviving Spouse of Certain Employees

(1) The Company will make suitable arrangements for a surviving spouse of an employee who was actively at work on or after October 29, 1979 whose loss of life results from accidental bodily injuries caused solely by employment with the Company, and results solely from an accident in which the cause and result

are unexpected and definite as to time and place, to participate in the coverages for which the employee was eligible at date of death as a part of the groups covered thereby, subject to availability of coverage; provided, however, such coverage shall terminate upon the remarriage or death of the surviving spouse.

The Company will contribute monthly for each such surviving spouse who elects such hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverage the applicable group premium or subscription charges for coverage for (a) self (b) 2 party or (c) family; provided, however, that the Company's contributions toward an HMO or any similar alternative health delivery options for hospital, surgical, medical, prescription drug, vision and hearing aid coverage will not be greater than the amount which the Company would have contributed had the surviving spouse been enrolled in the applicable local Blue Cross-Blue Shield Plan or another carrier underwritten by an insurance company unless the Company at its option waives this limitation in whole or in part; and provided further, however, that the Company's contributions for coverage under this paragraph for the month the surviving spouse becomes age 65 and subsequent months shall be made only for months that the surviving spouse is enrolled for Medicare Part B. The Company may, from time to time, request that such surviving spouse attest to the eligibility status of the children towards whose coverage the Company contributes. If the surviving spouse fails to comply with such request, the Company may reduce the surviving spouse's coverage to that of "self," unless it can be demonstrated that the survivor had an eligible child or eligible children. Where permitted under the policy or contract under which a surviving spouse is covered, the Company may permit such surviving spouse to

continue hospital, surgical, medical, prescription drug and hearing aid (but not dental or vision) coverage for those sponsored dependents who were enrolled for coverage at the time of the employee's death. Such surviving spouse shall pay the entire cost of coverage for sponsored dependents.

For the month the surviving spouse becomes age 65 and subsequent months during which the surviving spouse is not enrolled for Medicare Part B, the surviving spouse may continue for (a) self (b) 2 party or (c) family who were enrolled for coverage at the time of the employee's death, the hospital, surgical, medical, prescription drug and hearing aid (but not dental or vision) coverage by contributing monthly the entire group premium or subscription charges applicable to such continued coverage.

(2) The Company will make suitable arrangements for the surviving spouse of a deceased employee who was not eligible to retire at the time of the employee's death, provided they were legally married for at least one (1) year immediately prior to the employee's death and do not meet the criteria in (1) above, to continue for self, 2 party or family who were enrolled for coverage at the time of the employee's death, the hospital, surgical, medical, prescription drug and hearing aid (HSMDH) coverage (but not dental or vision) referred to herein as a part of the groups covered, provided they meet the criteria as indicated in (2)(a) below.

(a) The surviving spouse who, as of the employee's date of death, is age 45 or older or whose age when combined with the employee's years of credited service or company seniority on the date of death total 55 or more, will be eligible for twelve (12)

months of Company subsidized COBRA HSMDH coverage beginning the first of the month following the month in which the employee died. Company subsidized COBRA coverage will continue for an additional six (6) months for surviving spouses of employees with ten (10) or more years of credited service or company seniority. After such Company subsidized COBRA coverage ends, the surviving spouse may continue HSMDH coverage by paying the full COBRA premium amount for the remaining months of COBRA for a maximum of thirty-six (36) months after the employee's death.

(b) If the surviving spouse does not meet the criteria in (1) or (2a) above, the surviving spouse may continue HSMDH COBRA coverage by paying the full COBRA premium amount for up to thirty-six (36) months beginning the first of the month following the month in which the employee died.

(c) The surviving spouse described in (a) and (b) above enrolled in dental and vision coverage at the time of the employee's death may continue coverage by paying the full COBRA premium amount for up to thirty-six (36) months.

C. Post-Retirement Health Care Benefits

Pursuant to the terms of the Settlement Agreement dated June 10, 2009 between Chrysler Group LLC and the UAW, and approved by the United States Bankruptcy Court Southern District of New York, certain retirees are eligible for coverage under the UAW Retiree Medical Benefits Trust, (the "Trust"), as determined by the Trust. Accordingly, post-retirement health care coverage is not provided by the Company to employees upon retirement, except as noted below.

Eligibility for, and the terms of post- retirement medical benefits for employees who would be eligible, but for the UAW represented service requirement and whose immediate employment prior to becoming a UAW represented employee was as a non-represented employee of the Company, will be based on total years of service with the Company and the applicable plan for retiree medical benefits for non-represented employees.

D. Same-Sex Domestic Partner Benefits

Any reference in this Article to same-sex domestic partner, including the definition of spouse, shall be governed by the Discontinuation of Same-Sex Domestic Partner Status contained in letter C-41 of Exhibit B.

Section 2. Enrollment

A. Employee, Surviving Spouse

No employee or surviving spouse shall be covered under this Program unless he is eligible and has duly enrolled therefor. A surviving spouse eligible but not insured for hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverage under B.(1) above will be given an opportunity to enroll for such coverage, which coverage will become effective on the first day of the calendar month next following the month in which enrollment occurs, and may be retroactive to a date not more than twelve months prior to enrollment.

B. Enrollment Category

Group hospital, surgical, medical, prescription

drug, vision, hearing aid and dental coverage may include, at the option of the employee or surviving spouse, protection for (1) self, (2) 2 party, or (3) family, according to the eligibility provisions defined herein.

C. Dependent Enrollment

(1) General Provisions

(a) As used in this section, when reference is made to a person, i.e. "person A" being "dependent upon" another person, i.e. "person B," the term shall mean that "person B" may legally claim an exemption for "person A" under section 151 of the Internal Revenue Code, of 1986, as amended from time to time for federal income tax purposes.

(b) The provisions of this section apply with respect to enrollment of certain dependents of employees and surviving spouses who elect the options referred to above, and to enrollment of sponsored dependents under subsection (5) below. Unless specifically provided otherwise in the Program, such a dependent has no individual or personal right of enrollment, right to select a coverage option or right to continue coverages under the Program.

(c) The Company shall have the right of determining eligibility of a dependent, consistent with the provisions of this Program.

(d) An employee or surviving spouse claiming initial or continuing eligibility of a dependent shall furnish (i) the social security number of such dependent for whom they are claiming eligibility and for whom they are required to provide a social security number to claim an exemption on their

Federal income tax return. If the dependent has not been assigned a social security number at the time the eligibility claim is made, a social security number shall be obtained promptly and reported to the Company; and (ii) any other documentation that may be necessary to substantiate the claimed eligibility of a dependent. Refusal or failure to furnish a dependent's social security number or any other documentation necessary, when requested to do so, shall result in denial or withdrawal of eligibility for such dependent.

(e) Unless otherwise provided, a dependent who loses eligibility in accordance with the provisions of this Program and who once again meets the requirements for dependent eligibility, may have coverage reinstated. The effective date of coverage in such cases will be the first day of the month following the month in which a valid enrollment process is completed.

(f) When, as a result of oversight or error, an eligible employee, surviving spouse or dependent entitled to Company-sponsored coverage is not enrolled in a timely manner, coverage may be provided retroactive to the date of eligibility that would have been established if proper processing had occurred. However, in no event will retroactivity exceed twelve (12) months from the month in which the error or omission is discovered.

(g) Notwithstanding any other provisions of the Program, the Program shall provide coverages in accordance with the applicable requirements of a qualified medical child support order and establish reasonable procedures related to such orders as required by and consistent with the Omnibus Budget Reconciliation Act of 1993 (OBRA 93).

The Company will pay the group premium or subscription charges due for all retroactive coverage.

This retroactive enrollment provision shall not apply to surviving spouses who are not entitled to Company-paid coverage. Such surviving spouses electing to continue coverages on a self-paid basis must make such election within three (3) months following the month of the deceased employee's death, or within three (3) months of the last month for which the Company made contributions for health care coverages. This retroactive enrollment provision also shall not apply to principally supported children or sponsored dependents, as discussed in subsections (5) and (6) respectively below.

The Company, the Union and the respective carrier(s) will, from time to time, conduct educational campaigns stressing the need for enrolled employees, and surviving spouses to provide timely notification to the Company of changes in eligibility of all enrolled dependents.

(2) Spouse

(a) The spouse of an eligible and enrolled employee shall be eligible for coverage. A surviving spouse of an employee may not have or add a new spouse as a dependent.

(b) A spouse by common-law marriage shall be eligible for coverage only to the extent such relationship is recognized by the laws of the state in which the employee is enrolled, and the employee has met such requirements for documentation of the status as may be necessary by law and required by the Company.

(c) The effective date of coverage for a spouse shall be the later of the effective date of coverage for the employee or the date of marriage. For a common-law spouse, the effective date of coverage shall be the date of valid enrollment and receipt by the Company of any necessary supporting documentation.

(d) A spouse's eligibility for coverage shall cease on the earlier of:

(i) the date the employee's coverage ceases, except that, in the case of the employee's death, coverage shall cease on the last day of the month following the month in which the employee dies, unless the spouse is eligible for coverage as a surviving spouse as set forth in B. above, or

(ii) the date of the final decree of divorce.

(3) Children

The eligibility rules as described in sections (a) (i) and (ii) below will apply in regards to Hospital, Surgical, Medical, Drug, Dental, Vision, and Hearing Aid.

(a) Children of an employee or of the spouse of an eligible and enrolled employee shall be eligible for coverage if, as to each one, the following criteria are met:

(i) Relationship. The child must be the child of the employee, or of an employee's spouse, by birth, legal adoption, placement for legal adoption of a child under age eighteen (18), or legal guardianship. In the case of a child who has been placed for adoption with the primary enrollee, or an enrollee's spouse, such

enrollee or spouse must have assumed and retained a legal obligation for total or partial support of such child in anticipation of adoption consistent with the applicable provisions of OBRA 93.

(ii) Age. The child may be eligible until the end of the month in which the child attains age 26.

Coverage may also be continued beyond age 26 if the child has been determined to be totally and permanently disabled as described in (e) below.

(b) An eligible surviving spouse may not enroll a child unless the child was eligible to be enrolled prior to the death of the employee or, in the case of a child born after the death of the employee, unless such child is the issue of the surviving spouse's marriage to the deceased employee, and was conceived prior to such employee's death.

(c) The effective date of coverage for a child shall be the later of the effective date of coverage for the employee, or in the case of:

(i) Birth – the date of birth;

(ii) Legal Adoption – the date of residence in the employee's household or petition for adoption, whichever occurs later; or, in the case of a child who meets the criteria for placement for adoption under OBRA 93, the date of the assumption and retention of a legal obligation for total or partial support;

(iii) Legal Guardianship – the date guardianship becomes final in accordance with applicable laws subject to requirements in (4) below; and

(iv) Stepchild – the date the child becomes a member of the employee’s household.

(d) A child, as defined above, shall cease to be eligible for coverage as of:

(i) the end of the month in which the child attains age 26, except in the case of a totally and permanently disabled child (in the event coverage for a totally and permanently disabled child is continued, eligibility for such coverage shall cease as of the last day of the month in which the child ceases to be totally and permanently disabled, as defined in (e) below);

(ii) the date the employee’s coverage ceases, except that, in the case of the employee’s death, coverage for such dependent child shall cease on the last day of the month following the month in which the employee dies, unless such child is eligible for coverage as a dependent child of the surviving spouse of such employee; or

(iii) the last day of the month in which the primary enrollee, or the spouse of an eligible and enrolled employee, or the order of a court of competent jurisdiction, terminates the legal obligation for total or partial support for a child who met the criteria for placement for adoption under OBRA 93.

(e) For the purposes of (a) (ii) and (d) above, “totally and permanently disabled” means having any medically determinable physical or mental condition which prevents the child from engaging in substantial gainful activity and which can be expected to result in death or be of long-continued or indefinite duration.

Coverage will not be reinstated for a child:

(i) who first becomes totally and permanently disabled after the end of the calendar year in which age 24 is attained;

(ii) who was eligible for coverage as a totally and permanently disabled child, recovers, and after the end of such calendar year, again becomes so disabled; or

(iii) who was not eligible for coverage at the time of disability.

(4) Legal Guardianship Children

(a) Children residing with and related to the primary enrollee or current spouse by blood (up to and including second degree relatives) and for whom the enrollee provides support (as defined by the Internal Revenue Code of the United States) and who were reported as dependents on the employee's most recent income tax return or who qualify in the current year for dependency tax status, may be enrolled as legal guardians.

(b) Proof of legal guardianship will be required for enrollment and continued eligibility in the program.

(c) Coverage will be termed effective the earlier of the end of the year the child turns 19 or legal guardianship is terminated.

(5) Principally Supported Children

(a) Children residing with and related to an employee by blood or marriage and for whom the employee provides principal support (as defined by the Internal Revenue Code of the United States) and who

were reported as dependents on the employee's most recent income tax return or who qualify in the current year for dependency tax status, may be enrolled as principally supported children. Effective January 1, 2008, no new principally supported children will be eligible for coverage. Current principally supported children will be able to remain on coverage as long as eligibility requirements are maintained. If eligibility is terminated for any reason, re-enrollment will not be allowed.

(i) A surviving spouse may continue coverages for a principally supported child enrolled by the deceased employee prior to such employee's death, but may not enroll a new principally supported child unless such child was eligible to be enrolled by the deceased employee as of the date of death.

(ii) The continuation of coverage provision based on total and permanent disability as indicated above in item (3)(a)(ii) and (3)(d)(iv) and the residency waiver based on legal responsibility for the provision of health care, which apply to other children as indicated in item (3)(a)(iv), does not apply to principally supported children.

(iii) The other criteria of item (3)(a) apply to principally supported children.

(iv) The effective date of coverage for a principally supported child shall be the first day of the month following the month in which a valid enrollment process is completed and any necessary supporting documentation is received.

(v) Eligibility of a principally supported child shall cease as it would for any other child in accordance with item (3)(d).

(6) Sponsored Dependents

(a) An employee may obtain optional health care coverages (other than dental or vision) for dependents other than those specified in item C. (1), (2), (3), and (4), and (5) above. Such dependents will include persons who are related to the employee by blood or marriage, or if not related, resides with the employee as members of the household; provided, however, that sponsored dependents (other than a child being adopted by the employee or retiree) who are not citizens of the United States must reside in the United States for one (1) full year, and must be legally entitled to remain in the United States indefinitely before becoming eligible for coverage. Sponsored dependents must be dependent upon the employee for more than half of their support as defined by the Internal Revenue Code of the United States and must either qualify to be claimed as an exemption by the employee in the current year or have been claimed as an exemption on the employee's most recent Federal income tax return. They must be designated as sponsored dependents through a valid enrollment process as determined by the Company. The coverages shall be the hospital, surgical, medical, prescription drug and hearing aid coverages provided under the Program option elected by the employee. For the purposes of this paragraph, an adopted child shall be considered to be related to the employee "by blood."

(b) Coverages provided for a sponsored dependent enrolled at the time of an employee's death may be continued at the option of the employee's surviving spouse while such surviving spouse is enrolled for coverages as provided in B. above. A surviving spouse may not add any new sponsored dependents.

(c) The employee shall pay the full additional cost of coverages under this paragraph, and the Company shall not contribute toward the cost of health care coverages for any sponsored dependents.

(d) The effective date of coverage for an eligible sponsored dependent shall be the later of the effective date of coverage for the employee, or the first day of the month following the month of receipt by the Company of a completed enrollment form and any supporting documentation as may be required by the Company; provided, however, that the effective date of coverage for a sponsored dependent previously enrolled as such, and whose coverage as a sponsored dependent was discontinued, shall be the first day of the sixth month following the month of receipt by the Company of a completed enrollment form and any supporting documentation as may be required by the Company.

(e) Coverage for a sponsored dependent shall cease on the earlier of:

(i) the last day of the month in which the person ceases to meet the eligibility criteria set forth in (a) above,

(ii) the last day of the month preceding the month for which the required contribution was due but not paid, or

(iii) the date the employee's coverage ceases except that in the case of the employee's death, coverage for such sponsored dependent shall cease on the last day of the month following the month in which the employee dies, unless the sponsored dependent has coverage continued in accordance with (b) above.

Section 3. Plan Options and Alternatives

The Company will make arrangements to provide an opportunity for employees and surviving spouses to enroll in one of the coverage options available. The options are as follows:

A. Standard Care Network Option

This option provides health care coverages described herein with predetermination and review procedures required in order to receive full benefits for certain covered services. These procedures include but are not limited to predetermination, concurrent utilization review, retrospective utilization review and focused utilization review as set forth herein.

(1) Benefit Plan Arrangements

Under the Standard Care Network option, the Company shall make arrangements for employees, surviving spouses and their dependents to participate in group health care coverages under the following conditions:

(a) The Company will arrange for employees in Michigan actively on the payroll of the Company to participate in hospital, surgical and medical coverages provided under the National Account Program, as specified in Section 4. below:

(i) with revised provisions, as have been agreed upon between the parties, and included herein or in the Administration Manual, and;

(ii) with provision for the Blue Card Program (or another carrier's program) and the benefits it provides

as of April 1, 1995, for coverage of professional and facility benefits and payments to providers on behalf of eligible employees and surviving spouses including eligible dependents, outside the local carrier area.

(iii) with provision to provide benefits for mental health and substance abuse services in accordance with the terms and conditions as set forth in Section 5. to this Program, except that benefits for outpatient and physicians office services for persons not covered by the provisions of Section 5. are shown below:

Maximum of fifteen (15) outpatient and physician's office psychiatric care visits per individual per calendar year payable at 100% as follows:

<u>Visits</u>	<u>Percent Payable</u>
1-5	100%
6-10	90%
11-15	75%

(b) The Company shall continue its arrangements to make available to employees, eligible surviving spouses and eligible dependents the Prescription Drug coverage, including the Maximum Allowable Cost program provisions, provided under the National Account Program, as specified in the Administration Manual:

(i) a \$6.00 co-payment amount for each separate generic; a \$12.00 co-payment for each separate brand prescription; and a \$17.00 co-payment for each separate erectile dysfunction (ED) prescription order and refill purchased on a retail basis. Specialty medications must be filled through the Pharmacy Benefit Manager (PBM) specialty pharmacies. Coverage will be provided for a one-month supply of

disposable syringes and needles for injection of insulin when prescribed with a one-month supply of insulin.

(ii) a \$12.00 co-payment amount for each separate generic; a \$17.00 co-payment for each separate brand; and a \$21.00 co-payment for each separate ED prescription order and refill purchased on a mail order basis. Specialty medications must be filled through the PBM specialty pharmacies. Coverage will be provided for a three-month supply of 100 disposable syringes and needles for injection of insulin when prescribed with a three-month supply of insulin. Such mail order prescription drug benefit will be available to all employees and surviving spouses. Supplies up to 90 days may be prescribed; and,

(iii) certain prescription drugs that have been identified by the carrier are covered at retail, at the applicable co-payment for up to a 34-day supply, for an original prescription and up to two (2) additional for the refills. Enrollees must obtain additional refills (beyond 2) by mail order. If the enrollee chooses to continue to obtain refills through the retail network, the enrollee shall be responsible for 100% of the discounted cost of the drug. The carrier will maintain a list of these drugs and update the list on a regular basis.

(iv) for a covered multi-source brand name drug (a medication no longer covered by patent and for which chemically equivalent versions can be manufactured or marketed), the Program will pay at the generic level at retail and mail order. If an enrollee chooses to receive the brand name drug, the enrollee shall pay the appropriate generic co-payment plus the full difference in plan cost between the generic and the brand name drug.

(v) on the initial script (retail or mail), if the brand name drug is dispensed at the physician's discretion, the enrollee shall pay the brand name co-payment plus the difference (up to a maximum of \$10.00) in cost between the generic drug and the brand name drug. Enrollees or their physicians may request a review of the medical necessity of a brand name drug dispensed at the physician's discretion. If the review substantiates that the brand name drug was medically necessary, the enrollee shall be responsible for the appropriate brand name co-payment for the duration of the prescription and any amount paid in excess of the brand name co-payment, on the initial script, shall be refunded to the enrollee. If the medical necessity of the brand name drug was not established, the enrollee shall be responsible on subsequent prescriptions for the generic co-payment plus the full difference in plan cost between the generic and the brand name drug. For drugs that are classified as having a narrow therapeutic index by the FDA, the enrollee shall be responsible for the brand name co-payment. A pre-notification process will be used to communicate potential changes to the enrollee.

(vi) the following additional exclusions and limitations shall apply for all enrollees: a) Dapoxetine shall not be covered, b) non-sedating antihistamines shall not be covered, c) covered vitamins and essential minerals include, and are limited to, prenatal vitamins for females under the age of 49, Vitamin D derivatives prescribed to treat renal disease, Vitamin K prescribed for bleeding conditions, long-acting Niacin for treating heart conditions and potassium chloride.

(c) The Company shall continue its arrangements to make available the dental expense benefits set forth in Section 6. to this Program under arrangements made with Delta Dental Plan of Michigan.

(d) The Company shall continue its arrangements to make available the vision expense benefits set forth in Section 7. to this Program for employees. Davis Vision and other local plans will provide vision expense benefits as agreed to between the parties in lieu of those benefits set forth herein.

(e) The Company shall continue its arrangements to make available the hearing aid expense benefits set forth in Section 8. to this Program under arrangements made with Blue Cross and Blue Shield of Michigan or another local health carrier.

(2) Supporting Documents and Practices

(a) The hospital, surgical, medical, prescription drug, vision and hearing aid coverages provided in this item A. for employees in Michigan shall be provided as a part of the National Account Program referred to in Section 4. below, and shall include the benefits provided as of October 12, 2011 and the administrative practices and interpretations described in the Administrative Manual referred to in Section 4., National Account Program.

(b) The Company will arrange to make available as a part of the National Account Program referred to in Section 4. below, for employees outside Michigan actively on the payroll of the Company, through local Blue Cross and/or Blue Shield plans (or other carriers) in areas where benefits are now being provided by such carriers, in areas where benefits may be provided by other carriers, hospital, surgical, medical, prescription drug, vision and hearing aid benefits as nearly equal as practicable to but, except upon mutual agreement between the Company and the Union, not in excess of or less than below those provided for

employees in Michigan, subject to the condition that carriers of other organizations may be selected by mutual agreement of the Company and the Union.

(c) Hospital, surgical, medical, prescription drug, vision and hearing aid coverages for employees shall be provided under a National Account Program by agreement between the Company and Blue Cross and Blue Shield of Michigan (or another carrier), hereinafter referred to as "Control Plan." The Control Plan shall have responsibility for assuring that uniform coverages are provided for employees outside Michigan enrolled in local Blue Cross and Blue Shield carriers (or other carriers) as provided under this item A.

(d) Modifications of hospital, surgical, medical, prescription drug, vision, hearing aid and dental coverages resulting from the collective bargaining negotiations should not be interpreted to remove or limit any previously existing coverage except where more limited coverage has been specifically provided.

B. Alternative Health Care Plans or Arrangements

By mutual agreement between the Company and the Union, another underwriter or group of underwriters may be substituted for any underwriter or group of underwriters now or hereafter providing any group hospital, surgical, medical, prescription drug, vision, hearing aid, or dental coverages, or any combination thereof. In addition, by the mutual agreement of the parties, alternative plans of benefits with limited numbers of providers may be implemented, including narrow networks or other innovative health care delivery models, and substituted for the benefits

as provided in the Preferred Provider Organization option, Health Maintenance Organization option or the Standard Care Network Plan option. Such arrangements can be implemented for diagnostic radiology in addition to durable medical equipment and prosthetic and orthotic appliances, prescription drugs, vision, mental health and substance abuse care, and such others as may be agreed upon by the Company and the Union.

The Company has made arrangements for employees in certain areas to be provided the option to subscribe to alternative plans, including but not limited to health maintenance organizations (HMO's) and preferred provider organizations (PPO's) as a partial or complete substitute for the coverages provided above. The coverages provided under such alternative plans shall not be limited to a standard benefit package. Each individual option shall be offered only by mutual agreement between the Company and the Union.

All PPOs made available to employees will be required to attain accreditation from either the National Committee For Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC) on or before September 14, 2007. All HMOs made available to employees will be required to apply for National Committee for Quality Assurance review and to attain at least provisional accreditation. Any PPO or HMO which does not have the required accreditation will not be made available during the next open enrollment. Provided, that a plan may be offered or retained by mutual agreement of the parties.

All PPO's and HMO's shall also be required to publicly report NCQA, URAC, HEDIS and any other

data that may be relevant to consumer information needs unless otherwise mutually agreed to by the parties.

These arrangements will be continued, subject to the continued availability and the enrollment requirements of such plans. These same arrangements will be extended to employees in other areas served by similar alternative plans by mutual agreement between the Company and the Union.

(1) Preferred Provider Organization Option

This option provides health care coverages through access to a panel of providers who have agreed to provide services under the terms of participation established by the preferred provider organization such as limits on fees, and controls on quality and utilization. In order to receive full benefits for certain services, such services must be obtained through the organization's panel of providers; except that benefits for mental health and substance abuse services shall be provided in accordance with the terms and conditions as set forth in Section 5. of this Program.

A preferred provider organization assumes responsibility for conducting utilization reviews, predetermination of services, or other reviews necessary to promote quality of care and control costs. A preferred provider organization may place the panel physician and other providers at financial risk through capitation, withholding of a percentage of fees, or other mechanisms, or if not, will have other means to monitor and control utilization by individual providers on a continuous basis.

A preferred provider organization assumes responsibility for selection and periodic evaluation of hospitals, physicians, pharmacists, laboratories and other providers to ensure sufficient numbers and types of providers who are geographically distributed to allow adequate access for enrollees.

A preferred provider organization assumes responsibility for providing the scope and level of benefits described herein, monitoring the appropriateness of referrals to non-panel providers, taking corrective action with respect to providers when necessary, and implementing other administrative processes as required by the Company.

Under the office visit provision, the enrollee shall be responsible for 50% payment of covered services at the network fee schedule. Amounts paid by enrollees related to office visits will not be applied to the out of pocket maximums.

Urgent care center (UCC) visits are subject to a \$50.00 co-payment for each visit to a network UCC for covered services. For covered services obtained at a non-network UCC, the enrollee is responsible for the network UCC co-payment plus possible additional amounts in excess of the network allowed amount. The carrier's payment to a non-network UCC will be the network allowed amount for the same service, or if less the actual charges, minus the network UCC co-payment. The UCC co-payment will be waived if the enrollee is transferred directly from the UCC to an Emergency Room (ER). In this situation, the provisions for ER co-payment will then apply.

ER visits are subject to a \$100.00 co-payment for each visit to an ER. The ER co-payment will be

waived if the enrollee is admitted into the hospital directly from the ER to receive covered inpatient hospital services. If the enrollee receives covered ER services at a non-network provider and does not have the ability or control to select a network provider, the carrier will defend the enrollee on the basis that the allowed amount is the reasonable and customary reimbursement for the services or supplies in question. In such situations the enrollee is still responsible for the ER co-payment. The provisions for payment for covered services provided by a non-network provider as stated above are not applicable to ER coverage.

Payment for covered services provided by panel providers are subject to a \$150 single / \$300 family in network deductible. The following services will not be subject to the plan deductibles: Prescription drugs copay, office visit coinsurance, DME, P&O, MHSA, hearing, and certain preventive screenings. Preventive services are defined in Section 4D to include pap smear services, proctoscopic exam, mammography screening, PSA, early detection screening, immunization in (xxi), Hep C, well baby, and bone marrow screening.

Payment for covered services provided by non-panel providers, unless the employee, surviving spouse or eligible dependent is referred by a panel provider and prospectively approved by the PPO, will be 80% of the non-panel provider's reasonable and customary charges for the same service or, if less, the actual charges. The reimbursement to providers by the preferred provider organization will be reduced to reflect any waiver or forgiveness by a provider of the remaining 20%.

Under this paragraph, after the \$500 individual / \$1000 family out of network deductible has been met, the 80% out of network coinsurance limitation on payment for charges payable to non-panel providers by the preferred provider organization shall be applicable for all services received out of network with an unlimited out of pocket maximum.

Preferred provider organizations may seek Company approval to establish special contractual relationships with providers not otherwise included under the Program (e.g., freestanding ambulatory surgical centers), when it can be shown that doing so will improve quality of care and enhance cost competitiveness.

Preferred provider organization shall have the prescription drug provisions outlined in section A(1)(b) above.

(2) Health Maintenance Organization Option

This option provides coverages to enrollees through physicians, hospitals and other providers who have agreed to provide services under the terms established by the health maintenance organization to limit fees, assure quality and control utilization.

The types of coverages and the scope and level of coverages provided under this option may vary among health maintenance organizations and may be different than the coverages provided in A. (1), (2), except the co-payment levels outlined in section A (1)(b)(i) above that shall also be implemented January 1, 2012 for enrollees in the health maintenance organizations. HMO's shall have the prescription drug provisions outlined in Section A(1)(b) above but it is

recognized that some HMO's may not be able to or may be unwilling to administer the prescription drug design. In the event this should occur, the parties will jointly agree upon a design that achieves comparable savings. In addition, benefits for mental health and substance abuse services shall be provided in accordance with the terms and conditions as set forth in Section 5. of this Program.

Most health maintenance organizations provide health care coverages (including preventive care) that generally are managed for the enrollee by a primary care physician. The primary care physician is responsible for referring the patient to other providers of services. If such referral is not obtained, the enrollee may be responsible for charges incurred.

Under this option, if an enrollee receives services from a non-health maintenance organization provider, in a non-emergency situation or without a referral, such services may not be covered provided, however, in situations where a valid prescription drug order is written by a dental service provider or a mental health/ substance abuse service provider, where these services are carved out, the HMO will recognize such prescription order as a covered service.

Section 4. National Account Program

A. Master Group Operating Agreement

Blue Cross and Blue Shield of Michigan is designated as the Control Plan. The parties, by mutual agreement, may select another control plan carrier during the term of this agreement. The Control Plan is responsible for assuring that the hospital, surgical, medical, prescription drug, vision and hearing

aid expense benefits under the National Account Program are provided, and to this end, must accept responsibility for the implementation and overall administration of the National Account Program.

B. Applicability

Hospital, surgical, medical, prescription drug, vision and hearing aid expense benefits shall be provided under the National Account Program described herein for all employees, surviving spouses and their eligible dependents subscribing for the Standard Care Network option under the Collective Bargaining Agreements.

With respect to all eligible enrollees, the Company will arrange to make available as a part of the National Account Program, through local Blue Cross and/or Blue Shield carriers, or another carrier, in areas where benefits are now being provided by those carriers, and by other carriers, in areas where benefits may be provided by other carriers, hospital, surgical, medical, prescription drug, vision, and hearing aid benefits as nearly equal as practicable to (but, except upon mutual agreement between the Company and the Union, not in excess of or below) those provided for employees in Michigan, subject to the condition that plans of other organizations may, by mutual agreement of the Company and the Union, be substituted.

Under the National Account Program each local carrier under a written agreement with the Control Plan will provide uniform hospital, surgical, medical, prescription drug, vision and hearing aid benefits described herein in the local carrier's respective geographical area, except for those benefits which may be provided under alternative arrangements

by mutual agreement of the Company and the Union. If local carriers agree to provide the benefits described herein, they shall do so in accordance with administrative practices and interpretations established by the Control Plan. If in any geographical area a local carrier fails to enter into the agreement as stated above, or fails to perform in accordance with its agreement, the Control Plan shall provide the benefits in the geographical area to the extent that the Control Plan does not arrange with a local carrier to do so.

C. Administration and Implementation

It is the intent and expectation that all local Blue Cross and Blue Shield carriers, or another carrier serving the areas described will underwrite (assume the risk) and service (process claims) the specified National Account Program benefits in their respective geographical areas. Such Blue Cross and Blue Shield carriers, or another carrier, would be eligible to participate in the National Account Program if such carriers enter into formal participation agreements with the Control Plan.

If a carrier is restricted by local regulatory agencies or is otherwise unable or unwilling to underwrite any or all of the specified benefits of the National Account Program, this fact shall be formally reported by the Control Plan to the Parties.

If a local carrier does not underwrite and/or service the specified benefits, the Control Plan shall, unless the Parties mutually agree otherwise:

(1) Underwrite the specified benefits with the servicing being handled by the local carrier, or

(2) Underwrite those portions of the specified benefits not underwritten by the local carrier with the servicing being handled by the local carrier, or

(3) Underwrite and service the benefits in an area if the local carrier does not participate in any capacity, or

(4) Arrange for another local carrier in the region to underwrite and service the specified benefits, or

(5) Underwrite the specified benefits with the servicing being handled by another local carrier in the region.

It is also the intent and expectation that the Control Plan and local carriers shall carry out their respective obligations as specified in E. below and that all local carriers participating in the National Account Program should comply with the policies and procedures established by the Blue Cross and Blue Shield, or another carrier Medical Necessity Project. This will include, but not be limited to, the policy of not reimbursing for routine diagnostic tests upon hospital admission.

The Control Plan shall accept responsibility for assuring that carriers are complying with these policies and procedures. The Control Plan shall monitor and evaluate each local carrier's compliance and shall report semi-annually to the Joint Insurance Committee.

D. Administrative Manual

(1) Contents

An Administrative Manual developed by Blue Cross Blue Shield of Michigan or another carrier for the National Account Program for use by all participating local carriers shall be brought up to date as necessary. Blue Cross Blue Shield of Michigan or another carrier shall have the sole responsibility for any necessary revisions of the Manual so as to describe the benefits specified in the Collective Bargaining Agreements. Among other things, the Manual should:

(a) Explain the benefits and the regulations governing their payment.

(b) Include the standardized administrative practices and interpretations which affect benefits.

(c) List the limitations and exclusions of the coverage.

(d) Define all those terms related to the programs provided (such as facility, physician, etc.).

(e) Define eligibility for coverage as a dependent, including "Sponsored Dependents."

(f) Describe procedures for status changes and terminations.

(g) Define the data to be provided with respect to the operation of the National Account Program.

(h) Describe the Coordination of Benefits and Reimbursement for Third Party Liability provisions.

(2) Amendment

(a) The Control Plan shall forward copies of

any proposed Administrative Manual revisions to the Company and the Union. The Company and the Union, after joint discussion and review, will advise the Control Plan of any action to be taken regarding the proposed revisions. The Control Plan shall issue the official controlling revised edition of such Administrative Manual sections within 30 days of receipt of such advice of action.

(b) The following benefit additions, deletions or modifications for the SCN and PPO options have been incorporated in the Administrative Manual. Health Plan benefit enhancements effective January 1, 2008 and later will only be provided to employees who are active on or after September 15, 2007 and their covered dependents unless otherwise noted below in this section:

(i) Departicipating Hospitals

The Company will request Blue Cross and Blue Shield of Michigan, or another carrier in its capacity as Control Plan for the National Account Program to assure that each participating Blue Cross carrier, or another carrier institutes the following procedure in the event a hospital departicipates from its Blue Cross, or another carrier network.

(1) A carrier will give adequate notice at the earliest possible date to enrolled employees of a hospital's departicipation and of the payment arrangements in such a departicipating situation.

(2) For those patients already hospitalized before a hospital departicipates, full covered benefits will be paid until the end of the hospital stay or until the available days of care are exhausted.

(3) For patients admitted during the first 30 days after the initial date of each hospital's deparicipation, full covered benefits will be paid for all admissions to such deparicipated hospital until the end of the hospital stay or until the available days of care are exhausted. For patients admitted after such 30 days, the appropriate nonparticipating hospital rate shall apply, except as provided in 4. below.

(4) Upon admission in an emergency (as determined by the carrier) to a hospital that has deparicipated, when the member cannot be safely moved to a participating hospital, the member will be entitled to full covered benefits during the first five days of the hospital stay. After five days from the date of such emergency admission, payment will be at the appropriate nonparticipating hospital rate. If at any time during such an admission the patient is moved to a participating hospital, payment may be made for the reasonable charges for ground ambulance transfer of up to 25 miles, upon approval of the attending physician and the carrier. This approval must be based on the physician's medical certification that the transfer will not endanger the patient's health and of carrier certification that the subsequent stay will be of sufficient duration to justify the transfer. If transfer to a participating hospital cannot be arranged, either because such a transfer would endanger the patient's health or because the subsequent stay would not be of sufficient duration to justify transfer, full covered benefits will be paid until the end of such hospital stay or until the available days of care are exhausted.

If such a hospital regains its participating status within six months after deparicipating, the carrier will retroactively make payments for the balance of the hospital's reasonable charges (as determined by

the carrier) for covered services for patients admitted during the period of deparicipation. The carrier shall arrange that such payments relieve the patients of any further financial obligation with respect to covered services received during the deparicipation period, and that any portion of such balance previously paid by the patient shall be refunded.

(ii) Nonparticipating Hospital Rate

Effective January 1, 2024, Blue Cross or another health carrier's maximum payment for inpatient room and board charges with respect to nonparticipating general acute care hospitals will be \$500 per day and payment for inpatient ancillary charges at such hospitals will be up to \$50 per day (a total of \$550 per day). It is further agreed that, upon implementation, the daily benefit rate supersedes other benefit arrangements for inpatient services in nonparticipating general acute care hospitals in all areas serviced by the carrier(s).

Certain covered emergency services received in the outpatient department of a nonparticipating hospital will be paid on the same basis as if in a participating hospital. To qualify for payment, the claim must be for services related to a medical emergency or a serious bodily injury that requires immediate medical attention to avoid placing the enrollee's life in jeopardy, permanent damage to the enrollee's health or significant impairment of bodily functions. Treatment must be provided at the hospital immediately following the medical emergency or injury. Payment will not exceed the amount that would be paid to a participating hospital, and there can be no assurance that the payment will cover the entire amount billed by the hospital.

Present benefit arrangements shall continue to apply to admissions to nonparticipating hospitals which are not classified as general acute care hospitals.

When services are provided by a non-participating hospital eligible only for limited payment of covered services, payment for outpatient services shall be made up to \$50.00 for each condition towards the hospital's regular charges for covered services, except as otherwise provided for treatment of certain medical emergencies and accidental injuries.

(iii) Outpatient Physical Therapy

Coverage is provided for physical therapy when performed in the outpatient department of a hospital or in an approved free-standing physical therapy clinic. This benefit is limited to 60 visits annually per condition. The benefit period is renewable each calendar year, immediately following surgery related to the condition for which outpatient physical therapy benefits were originally provided or following a distinct aggravation of the condition for which physical therapy has been rendered. Physical therapy, speech therapy, hearing therapy and/or functional occupational therapy provided in the same visit shall be counted as one visit toward the total visit limitation. The outpatient physical therapy benefit includes coverage for separately billed speech, hearing, and functional occupational therapy (whether or not provided in conjunction with physical therapy).

Effective January 1, 2012 Independent Occupational Therapists (IOTs) and Independent Speech and Language Pathologists ISLPs are covered in-network subject to applicable benefit

plan design (deductible, coinsurance, out-of-pocket maximum and office visit coinsurance/ copayment).

In order for the IOTs and ISLPs to be covered they must meet Program Standards and be recognized by the state for direct reimbursement and be approved by the carrier for reimbursement for certain professional services in accordance with their training and licensure. The Program Standards shall include, but are not limited to, the requirements that the individuals be registered, certified and/or licensed as applicable under state law, be legally entitled to practice their specialties at the time and place services are performed, and that they render specified services which they are legally qualified to perform.

(iv) Body CAT Scans

Computerized Transaxial Tomography, is a covered benefit for diagnostic examinations of the head and certain parts of the body as approved by Medicare in those local carrier areas in which the Control Plan determines that controls have been established consistent with Control Plan criteria, including the requirement that benefits would be payable for body scans only when provided on equipment approved by a recognized area health planning agency or comparable approval organization.

The Company and Union will develop and implement a process, upon recommendation of the carriers, to review and approve, as may be necessary to meet the needs of covered persons in certain areas, CAT scanners, or other new imaging technology, including but not limited to Nuclear Magnetic Resonance Imaging and Positron Emission Transaxial Tomography, which do not meet the

approval requirements specified in this Program.

(v) Optional Second Surgical Opinion

Employees and their eligible dependents may voluntarily obtain a second opinion under the Optional Second Surgical Opinion Program.

Prior to proceeding with the surgery, it may be in the enrollee's best interest to receive another opinion about his/her condition, and in some cases, a second opinion may lead to alternative treatment. However, in order for the optional second surgical opinion to be paid for by the Company, the enrollee must make arrangements for the consultation through the Carrier's Pre-Determination Center. If the enrollee receives a Second Surgical Opinion, and with subsequent Plan approval, all services are covered in full, including the physician's consultation and any necessary x-ray and laboratory tests.

(vi) Spine and Joint Program

Effective January 1, 2024, or as soon as practicable, Spine and Joint Program services will be added to the existing services requiring prior authorization.

(vii) Durable Medical Equipment (DME)

Coverage for durable medical equipment (DME) rented or ordered shall be based on categories of equipment covered by Medicare.

In addition, the following items are covered, subject to any stated conditions and to the other provisions of the Program and this section, although

not Medicare-approved:

(1) blanket supports (also known as cradles);

(2) neuromuscular stimulators, if prescribed by an orthopedic or physiatric specialist;

(3) positioning transportation chairs, prescribed as alternatives to traditional wheelchairs for children fourteen (14) years of age and under, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders or congenital abnormalities;

(4) electromagnetic bone growth stimulators, prescribed as an alternative to bone grafting in cases of severe physical trauma involving non-union of long bone fractures (in excess of 90 days from the date of fracture), or failed bone fusion;

(5) portable insulin infusion pumps, prescribed only when the diagnosis is insulin-dependent type I diabetes mellitus and there is documentation by the physician of poor diabetic control (i.e., widely fluctuating blood sugar before mealtime, frequent episodes of insulin reaction, evidence of frequent ketosis), or dependent-type I diabetes mellitus complicated by pregnancy.

(6) pressure gradient supports (also known as burn pressure garments) prescribed for circulatory insufficiency conditions to promote and restore normal fluid circulation in the extremity (up to four times annually for chronic conditions unless there is a change in physical condition such as a gain or loss of weight of the patient), and when prescribed to enhance healing and prevent scarring of burn patients;

(7) phototherapy (bilirubin) light with photometer, for patients under the age of one (1) having a diagnosis of hyperbilirubinemia;

(8) special features which, although not subject to review and approval under Medicare Part B, are necessary to adapt otherwise covered equipment for use by children;

(a) deluxe equipment or features which are not medically necessary for the treatment of the enrollee's condition and required in order for such enrollee to be able to operate the equipment, provided, however, that benefits are limited to the comparable cost of basic, standard equipment.

(b) continuous passive motion device for use on elbow and shoulder after surgical treatment.

(viii) Prosthetic and Orthotic Appliances

Coverage is provided for individually fitted arch supports used with a shoe that is not attached to a brace for enrollees. Coverage is limited to arch supports that are prescribed in writing by a physician for an orthopedic, neuromuscular, vascular or insensate foot condition excluding flat feet that has failed to respond to a course of appropriate conservative treatment (e.g., physical therapy, injections, anti-inflammatory medications), or when prescribed following foot surgery or trauma when the patient is receiving arch supports as a part of post surgical care. All arch supports must be obtained from a provider in the P&O program. No additional payment will be made for separately billed charges for fitting each arch support. Arch supports shall be covered

once every 12 months and are limited to procedure codes L3000, L3020, L3030, and L3031.

Coverage for appliances (except for experimental or research appliances or devices) shall be based on appliances covered by Medicare, provided that coverage for therapeutic shoes prescribed for diabetics not eligible for Medicare shall be limited to the diagnoses established by the Control Plan.

The following items are covered subject to any stated conditions and to the other provisions of the Program and this Subsection, although not Medicare approved:

(1) any style of orthopedic footwear, other than a basic oxford, when the shoes are an integral part of a covered brace; and

(2) all orthopedic shoe inserts, arch supports, and shoe modifications.

(3) Wigs and appropriate related supplies shall be a covered benefit for all enrollees subject to the limitations outlined below for those enrollees suffering hair loss from the effects of chemotherapy.

(a) for the first purchase of a wig and necessary related supplies (stand and tape) coverage will be provided up to \$200.

(b) thereafter, at intervals of not less than 12 months, coverage will be provided up to \$125 towards the purchase of a wig and necessary related supplies.

Process for Updating Durable Medical Equipment and Prosthetic and Orthotic Appliance Coverages:

1. A procedure has been established for the ongoing periodic update of the durable medical equipment and prosthetic and orthotic appliance coverages.

2. Written notification of changes in Medicare Part B durable medical equipment and prosthetic and orthotic appliance coverages, and other recommendations for coverage changes, will be provided to the Company by the Control Plan. The notifications and recommendations shall include, but not be limited to, the following information:

(a) Quality of care, access and appropriate utilization concerns and proposed actions to resolve such concerns;

(b) Any item(s) being replaced by new item(s), and a plan for discontinuation of coverage for the replaced item(s); and

(c) Positive or negative impact on Program costs.

3. The Company will implement Medicare Part B coverage changes and review and approve or disapprove other Control Plan recommendations. When a change is made, an effective date will be established.

4. The Control Plan will advise appropriate Carriers of any changes which are approved through this procedure, the effective dates, and any applicable administrative rules.

(ix) Speech Therapy for Children

Speech therapy for congenital and severe developmental speech disorders is a covered service for children under six (6) years of age, when not available through other public agencies (e.g., state, school, etc.), up to sixty (60) visits annually. Benefits are payable after attainment of age six (6) for continuous treatment which began prior to age six

(x) Medically Necessary Private Room

Hospital expense benefits shall be provided in private accommodations when medically necessary for conditions set forth in the revised National Account Program Administrative Manual pages, reviewed and agreed to by the parties.

(xi) Hospice

The current National Hospice Care Program for the terminally ill will be continued. All covered persons except those enrolled in the Health Maintenance Organization option will be eligible.

Pre-hospice coverage will be provided for members and their families with a lifetime maximum of 28 visits. An enrollee is eligible for pre-hospice services by recommendation of a physician who certifies that the patient has been diagnosed with a terminal illness. The enrollee is admitted to the hospice program by order of a physician who certifies that the enrollee requires the type of care available through the hospice and that the enrollee has a life expectancy of twelve (12) months or less. Participation in the pre-hospice or the hospice program will not require the enrollee to waive curative care.

(xii) Plastic, Cosmetic and Reconstructive Surgery

Rhytidectomy shall be a covered procedure when there is secondary visual impairment resulting from conditions such as Bell's Palsy. In order for benefits to be payable, a medical review must result in the determination that secondary visual impairment exists and would be corrected by such surgery. Facility charges for non-covered plastic and cosmetic surgery are no longer covered.

(xiii) Ambulance Services

Coverage for ambulance services shall be provided under the following conditions:

(1) Ambulance services must be medically necessary.

(2) The provider of such ambulance services must meet Medicare criteria for approval.

(3) Ambulance benefits are provided for local ground transportation for purposes of:

(a) transferring (one-way or round trip) of a hospital inpatient, or patient seen in the emergency room to another local hospital when lack of needed treatment facilities, equipment or staff physicians exists at the first hospital, or

(b) transporting (one-way or round trip) of a hospital inpatient to a non-hospital facility for examination with a covered CAT scan and the following conditions are met:

- the services are not available in the hospital in which the individual is an inpatient or in a closer local hospital, and

- the free-standing facility providing the treatment is approved by the state planning agency or comparable approval process.

(c) for services provided on or after January 1, 2000 and for purposes of emergency transportation of:

- Transporting a patient one way from the scene of an emergency incident to the nearest available facility qualified to treat the patient.

- Transporting a patient one way or round trip from the home to the nearest available facility qualified to treat the patient.

- Medical emergency/accidental injury patients are provided one-way transportation from the home to the facility. Return trip will not be considered medically necessary following stabilization.

- Home-bound patients are provided round trip transportation from the home to the facility and back when medically necessary (other means of transportation could not be used without endangering the patient's health).

Ambulance services by air or water shall be covered and limited to the transportation of an enrollee one way from the scene of an emergency incident to the nearest available facility qualified to treat the patient.

(4) A physician must prescribe the services which necessitate use of ambulance transportation for services described in (c), (i) and (ii) above.

(xiv) Sterilizations

Male and female sterilizations shall be covered irrespective of medical necessity. Sterilization reversals are not covered.

(xv) Human Organ Transplant

Subject to the conditions listed below, Single Organ Transplants including Heart, Lung, Pancreas, Liver, Small Bowel, and Multi-Organ Simultaneous Transplants including Heart-Lung, Pancreas-Kidney, Small Bowel-Liver, and Liver-Kidney human organ transplants will be a covered benefit.

(a) The enrollee is accepted by the basic medical carrier as a transplant candidate.

(b) The transplant operation must be performed at a Center of Excellence approved by the carrier.

(c) Covered benefits for professional fees are limited to the maximum allowable payment for each transplant as determined by the carrier.

(d) Covered benefits will be reduced by any amount payable from other sources, such as foundations, grants, governmental agencies or programs, research or educational grants and charitable organizations.

(e) Except in emergency situations, each of these organ transplant procedures must receive

predetermination approval that such transplant is appropriate and medically necessary. The predetermination review will be based on information provided by the patient's hospital and physicians, as well as other professional sources, such as medical publications, local and/or national medical opinions and professional group studies, as well as other criteria upon mutual agreement of the parties.

(xvi) Technical Surgical Assistants

Technical surgical assistant services provided by a physician who actively assists the operating physician are covered when medically necessary and when related to covered surgical or maternity services.

(xvii) Pap Smear Services

Coverage is provided for laboratory and pathological services for one (1) routine Papanicolaou (PAP) smear per enrollee per calendar year to detect cancer of the female genital tract when prescribed by a physician. More frequent PAP smears will be covered only when specifically prescribed for one of the following conditions: previous surgery for a vaginal, cervical, or uterine malignancy; presence of a suspect lesion in the vaginal, cervical, or uterine areas as established through clinical examination; or a positive PAP smear leading to surgery and requiring a post-operative smear.

(xviii) Proctoscopic Examination

Proctoscopic examinations with biopsy are covered. Proctoscopic examinations without biopsy are covered once every three (3) calendar years after age 40 is attained.

(xix) Mammography Screening

Coverage is provided for routine mammography screening to detect breast cancer when prescribed by a physician. Benefits shall be provided in accordance with the following guidelines established by the American Cancer Society:

(1) a baseline mammogram between the ages of 35 and 39

(2) An additional mammogram for enrollees age 36-39 with a family history of breast cancer or other evidence of high risk; and

(3) a mammogram once each year for women age forty (40) and older; and

(4) The equipment including digital mammography to be used for such screening must be accredited by the American College of Radiology.

(xx) Prostate-Specific Antigen (PSA)

Coverage will be provided for a screening PSA (prostate-specific antigen) test once each calendar year for enrollees ages forty (40) and older, provided the test is performed in accordance with guidelines established by the American Cancer Society. PSA tests used to confirm a diagnosis of cancer or to track the progress of the disease and to determine the effectiveness of the treatment being given will continue to be covered regardless of age. Enrollees ages 30 and above with PSA levels greater than 20 ng/ml may receive a follow-up test within the same calendar year.

(xxi) Early Detection Screening and Immunization Program

Early Detection Screening coverage, age and frequency will be provided to enrollees as recommended by the U.S. Preventive Services Task Force (A or B) and the Centers for Disease Control and Prevention.

Immunization Coverage

The following immunizations in children, adolescents and adults are covered as recommended by the Advisory Committee on Immunization Practices. Current age, dosage and frequency of the immunizations can be found at www.cdc.gov/vaccines/recs/schedules. All immunizations are covered in-network only.

Diphtheria toxoid and tetanus	Measles, mumps, rubella (MMR)
Diphtheria, tetanus and pertussis (DTP)	Meningococca
H1N1 vaccine	Pneumococcal conjugate (PCV)
Hemophilus influenza B (HIB)	Pneumococcal polysaccharide (PPV)
Hepatitis A	Poliovirus, inactivated
Hepatitis B	Poliovirus, oral
Herpes Zoster (shingles)	Rotavirus
Human papilloma virus (HPV)	Varicella (chicken-pox)
Influenza	

(xxii) Observation Care Services

Outpatient observation care, facility charges and professional services in accordance with Blue Cross Blue Shield of Michigan payment criteria are covered benefits. The ER copayment will be waived if the enrollee is admitted into the hospital directly from the emergency room or if placed into observation care.

(xxiii) Hepatitis C

For enrollees 11-24 years of age, a Hepatitis C (HCV) screening is covered once per calendar year. For other enrollees, Hepatitis C (HCV) screening is covered if such enrollee is at risk or when signs or symptoms may indicate a Hepatitis C infection.

In addition to the above, the parties will develop educational material for distribution to all enrollees to provide awareness of the Hepatitis C virus.

(xxiv) Flu Shots

In network coverage is provided for one (1) flu shot, including the administrative cost of the injection per calendar year for employees, surviving spouses and their eligible dependents who are enrolled for coverage.

(xxv) Well Baby and Well Child

Coverage is provided for:

(a) up to five (5) Well Baby visits for children from 13 months of age through 35 months of age,

(b) one (1) Well Child visit per calendar year for children from 36 months of age through age 17.

(xxvi) Rabies

The series of six post-exposure passive immunizations for rabies is a covered benefit.

(xxvii) Bone Marrow Screening

A lifetime maximum benefit of one bone marrow screening will be available to enrollees.

(xxviii) Audiometric Testing

Enrollees are eligible for audiometric testing as a diagnostic tool under the hospital, surgical and medical provisions of the Program, for any condition, disease or injury of the ear.

(xxix) Pulmonary Function Evaluation

Coverage for pulmonary function evaluation shall be expanded to include testing performed in an approved outpatient facility.

(xxx) General anesthetics and, intravenous sedation when medically necessary and administered in connection with oral or dental surgery in either the inpatient or outpatient setting are payable.

(xxxi) Effective January 1, 2008, the pilot for cardiac rehabilitation will be discontinued. Cardiac rehabilitation will be a covered benefit for Non-Medicare enrollees when they have one of the following conditions/treatments: angina, heart attack, heart transplant, open heart surgery, or angioplasty. In order to receive the benefit enrollees must start cardiac rehabilitation services within 6 months of experiencing one of the conditions listed above. Program duration will be limited to 12 weeks of services or 36 visits.

(xxxii) January 1, 2008 services rendered by Physicians Assistants (PA) and Nurse Practitioners (NP) are covered in-network subject to the plan design

(deductible, coinsurance, out-of-pocket maximum and office visit coinsurance/ copayment as applicable).

In order for a PA and/or NP to be covered they must meet Program Standards for the given profession and be approved by the carrier for reimbursement for certain professional services in accordance with their training and licensure, which would be covered under the Program when performed by a physician. Reimbursement would be to the physician or PA/NP, but not both. The Program Standards shall include, but not limited to, the requirements that the individuals be registered, certified and/or licensed as applicable under state law, be legally entitled to practice their specialties at the time and place services are performed, and that they render specified services which they are legally qualified to perform.

(xxxiii) Other Health Care Reform Preventive Services

Covered services as a result of the 2010 Patient Protection and Affordable Care Act (PPACA) include all preventive benefits rated “A” or “B” by the U.S. Preventive Services Task Force, immunizations recommended by the Centers for Disease Control and Prevention, and evidence-informed preventive care and screenings for infants, children, adolescents and adults in guidelines from the health Resources and Services Administration. The services are covered at 100 percent when obtained from an in-network provider and when the main purpose of the office visit is to get preventive care. These services are not considered preventive when they are part of a visit about an existing illness or injury.

These services will continue to be provided pursuant to these terms even if it is later determined, by amendment, repeal or by judicial determination that any PPACA preventative services and medication provisions as set forth in PPACA section 2713 shall no longer apply. To the extent the PPACA preventive services and medications provisions are expanded, modified or otherwise interpreted by regulation, judicial pronouncement or authoritative agency directive such that the required coverage of preventive services and medications set forth herein in compliance with PPACA, the Company reserves the right to make required changes or, to the extent compliance is variable, the parties agree to meet and confer to discuss revisions set forth herein to determine the manner by which compliance will be achieved.

(xxxiv) Platelet Derived Growth Factor

Platelet derived growth factor is covered for wound healing for certain conditions as approved by the carrier.

(xxxv) Effective January 1, 2024, provide coverage for the diagnosis and outpatient treatment of Autism Spectrum Disorders. Benefits include:

- Outpatient Applied Behavioral Analysis (ABA) therapy, where medically appropriate, pursuant to ABA regulations are covered for the treatment of Autism disorders.
- Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) as part of ASD treatment.

- Psychiatric services, psychological services, non-applied behavioral analysis services and medical-surgical services are covered to diagnose and treat autism and are not subject to age restrictions.
- These services may be subject to applicable member deductibles, copayments, coinsurances as described in this Article III.

(xxxvi) Allergy Testing and Immunotherapy:

- Effective January 1, 2024, provide coverage for medically necessary and non-experimental allergy testing and immunotherapy services, including allergy serum. This benefit may be subject to applicable member deductibles, copayments, coinsurances as described in this Article III.

(xxxvii) Injections:

- Effective January 1, 2024, provide coverage for medically necessary injections where therapeutically appropriate and consistent with the medical policy of the carrier. This benefit is subject to applicable member deductibles, copayments, coinsurances as described in this Article III.

(xxviii) Ear Wax Removal

- Effective January 1, 2024, ear wax removal shall be a covered procedure

(xxxix) Chiropractic Benefits:

- Effective January 1, 2024, provide coverage for Osteopathic manipulation therapy, Chiropractic spinal manipulation therapy, for a combined maximum of 24 visits per member per calendar year. Chiropractic services must be administered by in-network Chiropractors and/or Osteopathic Physicians.

These Chiropractic services are subject to applicable member deductibles, copayments and coinsurances as described in this Article III.

(3) Interpretation

At the request of the Union, the Company or a participating local Blue Cross or Blue Shield carrier, or other carrier as the Control Plan shall provide written replies to questions regarding the interpretation on the Administrative Manual.

E. Utilization Review and Cost Containment

All carriers shall implement and maintain processes for predetermination, concurrent utilization review, retrospective utilization review and focused utilization review consistent with the criteria set forth below and in the Administrative Manual.

The Control Plan shall have responsibility for assuring that local carriers under the National Account Program have such utilization review processes in their respective local carrier areas.

(1) Definitions

(a) “Predetermination” means the process by which the necessity for a given health care service, appropriateness of the service or the proposed setting for the service, is reviewed and approved by a carrier before the performance of such service. The review and approval are performed by qualified health care professionals as determined by the Control Plan, employed or retained by the carriers, using accepted standards to examine pertinent medical documentation of the need, appropriateness and setting for such service.

(b) “Concurrent utilization review” means the process by which continued need for inpatient treatment is reviewed while the patient is receiving inpatient care. Determination of the need for continuation of such treatment is performed by qualified health care professionals, as determined by the Control Plan, employed or retained by the carriers, using accepted standards to review pertinent medical documentation of such need.

(c) “Retrospective utilization review” means the process by which the necessity, appropriateness and setting of a given health care service is reviewed following the performance of the service. The review is performed by qualified health care professionals, as determined by the Control Plan, employed or retained by the carriers, using accepted standards to examine pertinent medical documentation of the need, appropriateness and setting for such service.

(d) “Focused utilization review” means the process by which intensive review of certain providers (professionals and facilities) and/or diagnoses is

conducted in cases where such providers and/or diagnoses have been identified as warranting such review. The review is performed by qualified health care professionals, as determined by the Control Plan, employed or retained by the carriers, to audit the necessity of a given health care service, appropriateness of the service, the setting of the service, the quality of care rendered, and the financial accuracy of claims submitted for reimbursement related to such services.

(2) Predetermination

Under the Standard Care Network option, the carriers shall continue to provide predetermination for services under paragraphs (1) through (5). PPOs may perform their own predetermination, and some variations in administration may exist.

(a) All hospital admissions except maternity and emergency (emergency admissions are to be reported to and reviewed by the carriers within 24 hours of inpatient admission);

(b) Any nonemergency, outpatient medical or surgical procedures performed in a facility or a physician's office which are associated with certain diagnoses determined by retrospective utilization review to be subject to over utilization and amenable to control by predetermination;

(c) All ancillary services provided in inpatient and outpatient settings (including home health care) which are associated with certain diagnoses determined by retrospective utilization review to be subject to over utilization and amenable to control by predetermination;

(d) All medical equipment, prosthetic and/or orthotic devices prescribed for certain medical conditions determined by retrospective utilization review to be subject to over utilization and amenable to control by predetermination;

(e) All nursing home admissions.

All covered services listed above shall be referred to the carriers for predetermination according to standards and procedures set forth in the Administrative Manual. However, the carriers may focus their review by diagnosis, treatment plan, and/or individual patient characteristics. The carriers shall recommend outpatient or office settings as appropriate for selected procedures and diagnostic tests. The carriers shall use discharge planning to facilitate transfer to more cost effective settings as appropriate. The carriers may recommend alternative treatment plans as appropriate.

The predetermination of inpatient care shall include the designation of appropriate lengths of stay based on diagnosis, patient characteristics, and/or appropriate practice patterns. An appeal process for adjusting the assigned length of stay in individual cases will be available for use as needed. The carriers will provide to the Company and the Union such data and reports on the performance of the predetermination program as may be requested.

The carriers shall establish and maintain a telephone service and other appropriate communication methods to provide accurate information to covered persons and providers regarding the program procedures and requirements. Such communications will specify the responsibilities

of providers and covered persons in obtaining necessary predetermination. Such communications will include forms and letters, as appropriate, to indicate confirmation and nonconfirmation and will be provided to physicians, facilities, and covered persons by the carriers. All communications will be designed to assist providers and covered persons to secure the required predetermination.

Identification cards furnished to covered persons by the carriers shall contain toll-free telephone numbers for obtaining predetermination information or other required approvals of services.

The carriers shall provide timely written notification of any actions taken with respect to the predetermination process. Such notification will be mailed to the provider and the covered person. Such notification shall be mailed within 24 hours following receipt by the carrier of oral or written request for predetermination.

An appeal procedure will be available for independent medical review of disputed decisions prior to receipt of services. Decisions resulting from such an appeal procedure will be final and binding on the provider, covered person and carrier.

Benefits for certain covered services, which require predetermination, when provided without obtaining necessary predetermination approvals will be payable at 80% of reasonable and customary charges after the first \$100 of expense for such services. The reimbursement to providers will be reduced to reflect any waiver or forgiveness by a provider of the \$100 or remaining 20%.

Under this paragraph, the 80% limitation on payment for reasonable and customary charges and the requirement that payment be made for the first \$100 of covered expenses shall not be applicable (i) to an individual who has incurred a personal expense of \$750 for such covered services in a calendar year or (ii) to the covered members of the individual's family, if any, after the individual and such members have incurred a total of \$1,500 in personal expense for such covered services in the same calendar year.

A procedure will be available for carriers to hold the covered person harmless for errors of commission or omission involving the predetermination process over which the covered person has no control. This procedure shall be published in the Administrative Manual. The carriers shall require participating providers to hold the covered person harmless from the provider's errors of commission or omission involving the predetermination process.

The carriers shall monitor for and identify providers who have a pattern of inappropriately prescribing services. The carriers shall provide selective screening of such identified providers. The carriers also shall provide screening for diagnoses identified as being subject to such inappropriate practices.

(3) Concurrent Utilization Review

The carriers shall provide a process of concurrent utilization review to supplement the predetermination process. Through this procedure of concurrent utilization review, the carriers shall identify providers who utilize services inappropriately and develop educational and/or corrective action programs for these providers.

(4) Retrospective and Focused Utilization Review

The carriers shall develop a program to conduct ongoing retrospective review which will include audits of claims for medical necessity, appropriateness of services provided, treatment setting, quality of care, and financial accuracy. At the option of the carriers, this review can focus on specific diagnoses and/or providers identified as warranting such focused review.

Such review may occur post-payment; however, the carriers should develop and implement a plan for making this review, where practicable, pre-payment (or pre-settlement with respect to providers paid on a prospective basis).

(5) Data

All carriers will provide to the Company and the Union such data and reports as may be requested to determine the effectiveness of various processes including but not limited to predetermination, concurrent utilization review, retrospective utilization review, focused utilization review, human organ transplants, the mail order prescription drug program.

The Control Plan shall be responsible for ensuring that local carriers provide such data and reports on a quarterly basis and are in compliance with providing the utilization review and cost containment programs as specified in the program.

(6) Pilot Programs

The Committee shall request development by the

Control Plan for the National Account Program or by participating local carriers, and, where applicable by commercial or other carriers, of specifications for new or modified Pilot Programs for Committee review and evaluation. The Pilot Programs shall be implemented after Committee approval of the proposed program specifications and evaluation criteria, including mutually agreed-upon modifications.

In the development of these Pilot Programs, the Control Plan, local carriers, and commercial or other carriers shall secure the advice of professional and medical associations, as appropriate.

Any Pilot Program may be modified or terminated by mutual agreement if it appears that positive results are not forthcoming.

(7) Other Activities

The Committee shall investigate, consider and, upon mutual agreement, engage in other activities that may have high potential for cost savings. This may involve instituting by mutual agreement other hospital, surgical, medical, prescription drug, dental and vision Pilot Programs or extending the Pilot Programs in (6) above, to additional locations.

(8) Review

The results of any Pilot Programs and Activities in (6) and (7), above, would be reviewed prior to the expiration of the collective bargaining agreements so that the parties to the agreement may be prepared to consider the continuation or modification of the Pilot Programs and other activities of the Committee.

F. Data

The Control Plan annually will furnish the Company and the Union such information and data as may be mutually agreed upon by the Parties with respect to coverages provided under the National Account Program.

G. Performance

The Control Plan shall be responsible to ensure that carriers participating in the National Account Program provide the scope and level of benefits as specified in the program and in the Administrative Manual. The Control Plan, with such assistance from the national Blue Cross and Blue Shield, or another carrier organizations as may be appropriate may, in exercising its responsibilities, audit local carriers to determine if they are providing the specified level of benefits.

H. Relationships to Providers of Service and Participating in Community Health Planning

It is expected that the Control Plan and the participating carriers will maintain continuing and close relationships with the providers of health services and will actively participate in comprehensive community health planning.

I. Miscellaneous Administrative Understandings

(1) The Control Plan will be requested to ask carriers participating in the National Account Program to:

(a) Designate a person or persons whom individuals, Union and management representatives

may contact regarding the status of individual claims or individual employee problems. Carriers will be requested to keep the Union and management representatives advised of the name(s) of the person(s) to whom such inquiries should be made.

(b) Develop a periodic follow-up procedure for claim inquiries and advise the party making the inquiry of the status of the carrier's investigation regarding specific claims.

(c) Submit written replies upon request of individuals, including Company or Union representatives, regarding inquiries concerning denied or disputed claims.

(d) Have a procedure for obtaining review of disputed claims by physicians employed or selected by the carrier if such disputes exist because of a question regarding a medical opinion.

(2) The Control Plan will set up a mechanism to resolve disputed claims involving an interpretation of the scope or level of benefits under the National Account Program. Final determination of any disputed claims which involve the interpretation of the scope or level of benefits under the National Account Program will be the responsibility of the Control Plan.

Section 5. Mental Health and Substance Abuse (MHSA)

All covered persons enrolled in the Standard Care Network option, Preferred Provider Organization option or Health Maintenance Organization option unless otherwise agreed to by the parties shall be provided Mental Health and Substance Use Disorder

Benefits administered in accordance with the terms and conditions set forth herein.

A. Enrollment Classifications

Mental Health and Substance Use Disorder Benefits for an eligible employee or surviving spouse shall include coverage for eligible dependents as they are defined in the National Account Program. Surviving spouses and their eligible dependents enrolled for Medicare are not subject to the terms and conditions described herein. Applicable benefits are shown below.

B. Description of Benefits

Mental Health and Substance Use Disorder Benefits will be payable, subject to the conditions herein, if any covered person, while mental health and substance use disorder coverage is in effect with respect to such covered person, receives covered mental health or substance use disorder services.

C. Definitions

As used herein:

(1) “mental disorders” means any mental, emotional or personality disorder classified in categories F01 to F99. Inclusive in this range are substance use disorder conditions in categories F10 through F19 in the most recent edition of the “International Classification of Diseases (ICD), Clinical Modification.”

(2) “managed care” means the process by which the medical necessity, appropriateness, and setting of

a mental health or substance use disorder service is reviewed prior to the performance of the service and during the course of an enrollee's treatment.

(3) "managed care unit" is an entity established by the program administrator and staffed by qualified mental health and substance use disorder professionals, including psychiatrists, addictionologists, licensed psychologists, master's level clinical social workers, master's level clinical psychiatric nurses, and master's level substance use disorder counselors.

(4) "panel provider" means an acute care general hospital, psychiatric hospital, residential facility, partial hospitalization, intensive outpatient program, outpatient psychiatric clinic, psychiatrist, licensed psychologist, master's level clinical social worker, master's level nurse clinician or master's level counselor licensed to practice by the state where the service is delivered at the independent practice level and under contract with the program administrator to provide treatment to eligible enrollees in accordance with specific terms and conditions established by the program administrator including, but not limited to, limits on reimbursement, quality protocols and criteria, and utilization controls.

(5) "partial hospitalization" means treatment at a semi-residential level of care for patients with a mental health or substance use disorder who require coordinated, intensive, comprehensive and multi-disciplinary treatment in a structured setting, but less than inpatient hospitalization. The patient undergoes therapy for more than four (4) hours a day, and may receive additional services (e.g. meals, recreation).

D. Program Description

(1) A Mental Health and Substance Use Disorder program administrator will manage the intake, assessment, referral and treatment monitoring of all inpatient benefits, psychological testing and select outpatient mental health and substance use disorder cases. The program administrator will be accessible through a toll-free number available 24 hours a day, seven days a week. Enrollees requiring mental health and/or substance use disorder services may contact either the program administrator or a panel provider, in which case, the panel provider will perform an assessment, develop a preliminary treatment plan, and then call the program administrator for treatment pre-determination.

(2) Managed care services will include the following:

(a) triaging calls from program enrollees or providers.

(b) providing program enrollees with treatment referrals to panel providers.

(c) performing concurrent reviews during course of treatment plan.

(d) conducting follow-up activities to assure that enrollees who have completed a course of treatment are satisfied with the outcome of the treatment and that services are available if required.

(e) coordinating inpatient and outpatient treatment to promote quality of care and continuity of services.

(f) coordinating substance use disorder and surgical medical benefits to ensure that surgical medical services included in substance use disorder claims are allocated to the appropriate plan administrator.

(g) referring enrollees to the assessment panel for a comprehensive, face-to-face diagnostic evaluation when it is not possible to determine the nature of the enrollee's circumstances through the intense telephone review process.

(h) developing a continued treatment plan in instances when the extension of a benefit will avert a more costly treatment modality.

(3) An appeal procedure will be available for panel providers in those situations where there is disagreement over the treatment recommendation authorized by the program administrator. If the dispute cannot be resolved by review on behalf of the program psychiatric consultant, the case may be referred to an appeals committee comprised of the carrier's mental health professionals. If the dispute is still unresolved, the case may be referred to an independent review body. Decisions resulting from such an appeal are binding on the provider, covered person, and program administrator.

E. Benefits

(1) Terms and Conditions of Benefit Payment

A covered person is eligible for benefits for covered expenses incurred while undergoing treatment under this program only if the following conditions are met:

(a) Admission to a treatment plan occurs on or after the covered person's effective date of coverage under the Program.

(b) All psychiatric and substance use disorder inpatient, residential and partial hospitalization admissions must be reviewed by the program administrator to determine the appropriateness of setting.

(c) A non-psychiatric physician, physician assistant, or nurse practitioner may provide psychiatric medication management but must contact the program administrator if more than three (3) visits are required.

(d) Services and referrals to non-panel providers can be covered at the in-network benefit level, provided they are approved by the program administrator.

(e) Emergency services are covered regardless of whether the provider is in the panel or not, however, the provider should notify the program administrator for authorization of treatment.

(2) Benefit Period

Under this program, mental health and substance use disorder benefits include the following:

(a) A maximum of 365 days of inpatient nervous and mental care. (For a new benefit period to begin, there must be a lapse in treatment of at least 60 consecutive days between the date of last discharge from a hospital, skilled nursing facility, residential treatment facility, mental health facility, or any other facility to which the 60-day benefit renewal

period applies and the date of the next admission, irrespective of whether or not benefits were paid. Such 60-day period is broken if/when the enrollee/patient receives home health care services, whether or not benefits are paid as a result of receipt of such services. Treatment received during the 60-day period need not be related to the original medical condition).

(b) The 365-day benefit limitation applicable to the hospital inpatient treatment of nervous and mental conditions also applies to the treatment of substance use disorder in program administrator-approved residential facilities. Each day of care utilized under the residential substance use disorder treatment program is charged against the unused portion of the 365-day inpatient nervous and mental benefit period.

Likewise, each day of inpatient nervous and mental care is charged against the residential substance use disorder treatment period. The benefit renewal conditions described in (2)(a) apply to this benefit as well.

(c) A maximum of 365 days of day or night care services is available for nervous and mental or substance use disorder treatment. The benefit renewal conditions described above apply to this benefit as well.

(d) Coverages for outpatient mental health and substance use disorder care (subject to the following schedule for professional services) are as follows:

Outpatient – 35 visits/year

– visits 1-20 paid in full

- visits 21-35 paid in full for substance use disorder patients
- visits 21-35 paid at 75% for mental health patients with a maximum member cost of \$25.00 per visit for enrollees in the SCN option
- visits 36 and beyond subject to a \$25.00 co-payment per visit for both facility and professional services per calendar year for enrollees in the SCN option
- visits 36 and beyond subject to a 50% co-insurance payment per visit for professional services per calendar year for enrollees in the PPO option

(e) Psychological testing

(3) Coverages

(a) For an authorized admission to an acute care hospital or residential treatment facility, an enrollee is eligible to receive the following covered services when provided and billed by the facility:

(i) bed and board, including general nursing service;

(ii) laboratory examinations related to the treatment received in the facility;

(iii) drugs, biologicals, solutions and supplies related to the treatment received and used while the enrollee is in the facility;

(iv) supplies and use of equipment required for detoxification or rehabilitation;

(v) all professional and ancillary services, including those of other trained staff, necessary for patient care and treatment, including diagnostic examinations;

(vi) individual and group therapy or counseling;

(vii) psychological testing; and

(viii) counseling for family members.

(b) For an admission to a partial hospitalization treatment program or outpatient treatment facility, an enrollee is eligible to receive the following covered services when provided and billed by the facility:

(i) laboratory examinations related to the treatment received in the facility;

(ii) drugs, biologicals, solutions, and supplies related to the treatment received, including drugs to be taken home;

(iii) supplies and use of equipment required for detoxification or rehabilitation;

(iv) all professional and ancillary services, including those of other trained staff, necessary for the treatment of ambulatory enrollees, including diagnostic examinations;

(v) individual and group therapy or counseling;

(vi) psychological testing; and

(vii) counseling for family members.

(c) Coverage for authorized outpatient mental health or substance use disorder services includes:

(i) all professional and other staff and ancillary services made available to ambulatory patients;

(ii) prescribed drugs and medications dispensed by the facility in connection with treatment received at the facility;

(iii) psychological testing; and

(iv) counseling for family members.

F. Sanctions

(1) Services provided from panel providers without obtaining necessary predetermination within 24 hours of admission will not be payable. The covered person will be held harmless by the program administrator for errors of commission or omission involving the predetermination requirement over which the covered person has no control.

(2) Services provided from non-panel psychiatrists or addictionologists without obtaining the necessary waiver authorization from the program administrator will be payable at 50% of the usual, customary, and reasonable rate.

(3) Services provided by mental health professionals (i.e., licensed psychologists, master's level clinical social worker, master's level nurse clinician, master's level certified substance use disorder counselor, master's level licensed professional counselor, or physician assistants), who are not in the panel will not be reimbursed for unauthorized care.

(4) Services provided by non-psychiatric physicians, physician assistants and nurse practitioners who, by definition, will not be in the panel, will be covered up to three visits, after which unauthorized treatment will be payable at 50% of the usual, customary, and reasonable rate.

(5) Services provided from non-panel facilities without obtaining the necessary waiver authorization will be payable at 50% of approved charges up to the maximum allowable payment.

(6) The Company and Union have expressed a mutual concern for employees and dependents who fail to complete their substance use disorder continuing care treatment plans. The parties agree to monitor such use patterns. If the Company and Union determine that a prevalent problem exists and needs to be addressed, the Company and Union will meet promptly to discuss appropriate corrective actions. By mutual agreement such actions may include future financial penalty for persons who do not complete their substance use disorder treatment plans.

(7) Non-emergency mental health and substance use disorder inpatient services provided by non-panel providers without referral by a panel provider are included in out-of-pocket maximums and subject to non-panel payment limitations as described in Article 3, Section 3 B (1) for the PPO option and Letter C-49 for the SCN option.

G. Exclusions

Benefits are not payable for:

(1) Services for mental disorders which,

according to generally accepted medical standards, are not amenable to favorable modification, except that benefits are available for the period necessary to determine that the disorder is not amenable to favorable modification, or for the period necessary for the evaluation and diagnosis of mental deficiency or retardation.

(2) Dispensing methadone or testing urine specimens, unless therapy, counseling, or psychological testing are provided.

(3) Diversional therapy.

H. Coordination of Benefits

Coordination of benefits will be administered under the same provisions applicable to the National Account Program hospital, surgical, medical, prescription drug, vision, hearing aid, and dental coverages.

I. Reimbursement for Third Party Liability – Subrogation

Reimbursement for Third Party Liability – Subrogation will be administered under the same provisions applicable to the National Account Program hospital, surgical, medical, prescription drug, vision, hearing aid, and dental coverages.

Section 6. Dental Expense Benefits

A. Enrollment Classifications

Dental Expense Benefits coverage for an eligible employee or surviving spouse shall include coverage for eligible dependents as defined for National Account

Program hospital, surgical, medical, prescription drug, vision and hearing aid coverage.

B. Description Of Benefits

Dental Expense Benefits will be payable, subject to the conditions herein, if an employee, surviving spouse, or eligible dependent, while dental expense coverage is in effect with respect to such individual, incurs Covered Dental Expenses.

C. Covered Dental Expenses

Covered Dental Expenses are the usual charges of a dentist which an employee or surviving spouse is required to pay for services and supplies which are necessary for treatment of a dental condition, but only to the extent that such charges are reasonable and customary charges, as herein defined, for services and supplies customarily employed for treatment of that condition, and only if rendered in accordance with accepted standards of dental practice. Such expenses shall be only those incurred in connection with the following dental services which are performed, except as otherwise provided in G.(2), by a licensed dentist and which are received while insurance is in force.

(1) The following Covered Dental Expenses shall be paid at 100 percent of the usual, reasonable and customary charge.

(a) Routine oral examinations and prophylaxis (scaling and cleaning of teeth), but not more than twice each in any calendar year. Three cleanings per calendar year will be allowed if there is a documented history of periodontal disease. Four cleanings per

calendar year will be covered for two full calendar years following periodontal surgery.

(b) Topical application of fluoride, provided that such treatment shall be a Covered Dental Expense only for persons under 15 years of age, unless a specific dental condition makes such treatment necessary.

(c) Space maintainers that replace prematurely lost teeth for children under 19 years of age.

(d) Emergency palliative treatment.

(e) Fluoride trays used in the delivery of topical fluoride for enrollees undergoing radiation therapy of the head and neck due to cancer, payable once with initial cancer diagnosis and thereafter once with each subsequent recurrence of cancer, as medically necessary.

(f) Oral Exfoliative Cytology (brush biopsy). Coverage includes collection of the biopsy specimen and its laboratory interpretation, performed in the dental office, when an enrollee presents with an unresolving oral lesion/ulceration, or an enrollee with an oral lesion/ulceration has a history of behaviors that places the enrollee at risk for oral cancer. One brush biopsy per calendar year will be covered, subject to Program standards.

(2) The following Covered Dental Expenses shall be paid at 90 percent of the usual, reasonable and customary charge.

(a) Dental x-rays, including:

(i) full mouth x-rays, once in any period of five (5) consecutive calendar years,

(ii) supplementary bitewing x-rays once in any calendar year for enrollees age 14 and younger; and every twenty-four (24) months for enrollees age 15 and older, and

(iii) such other dental x-rays, including but not limited to those specified in (a) and (b) above, as are required in connection with the diagnosis of a specific condition requiring treatment.

(b) Extractions, except those described in C.(3) (d).

(c) Oral surgery, except as described in C.(3) (d).

(d) Amalgam, synthetic porcelain, and composite resin based composite filling restorations to restore diseased or accidentally injured teeth.

(e) General anesthetics and, intravenous sedation when medically necessary and administered in connection with oral or dental surgery.

(f) Treatment of periodontal and other diseases of the gums and tissues of the mouth.

(g) Endodontic treatment, including root canal therapy.

(h) Injection of antibiotic drugs by the attending dentist.

(i) Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing

of dentures more than six (6) months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of three (3) consecutive calendar years.

(j) Inlays, onlays, gold fillings, or crown restorations to restore diseased or accidentally injured teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, synthetic porcelain, or resin composite filling restoration.

(i) Replacement of inlays, onlays, gold fillings or crown restorations on the same tooth, if at least five (5) years have elapsed since initial placement. Replacements earlier than five years are not covered.

(k) Cosmetic bonding of eight (8) front teeth for children 8 through 19 years of age if required because of severe tetracycline staining, severe fluorosis, hereditary opalescent dentin, or amelogenesis imperfecta, but not more frequently than once in any period of three (3) consecutive calendar years.

(l) An occlusal guard (maxillary or mandibular) is a covered supply only for palliative treatment of bruxism and/or acute pain of the muscles of mastication. The benefit is payable for one occlusal guard in a five-year period.

(m) The placement of an endosteal, single tooth, implant and implant abutment, and crown, including any supportive services with the exception of IV sedation and/or general anesthesia. Coverage does not include bone grafts or specialized implant surgical techniques.

(3) The following Covered Dental Expenses shall be paid at 50 percent of the carrier's allowed amount.

(a) Initial installation of fixed bridgework (including inlays and crowns as abutments)

(b) Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six (6) month period following installation).

(c) Replacement of an existing partial or full removable denture or fixed bridgework, by a new denture or by new bridgework or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

(i) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or,

(ii) The existing denture or bridgework was installed under this Dental Expense Benefits Program at least five (5) years prior to its replacement and the existing denture or bridgework cannot be made serviceable; or,

(iii) The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

Normally, dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a

Covered Dental Expense.

(d) Orthodontic diagnostic procedures and treatment (including related oral examinations, surgery and extractions) consisting of surgical therapy, appliance therapy, and functional/myofunctional therapy (when provided by a dentist in conjunction with appliance therapy) for persons under 19 years of age, provided, however, benefits will be paid after attainment of age 19 for continuous treatment which began prior to such age, and provided further, orthodontic diagnostic procedures, oral surgery and extractions shall be paid at 90% of the usual, reasonable and customary charge and shall not be charged against maximum benefits payable for orthodontics.

D. Maximum Benefit

The maximum benefit payable for all Covered Dental Expenses incurred during any calendar year commencing January 1 and ending the following December 31 (except for services described in C.(3)(d) above), shall be \$2,000 for each individual.

For Covered Dental Expenses in connection with orthodontics including related oral examination, surgery and extractions described in C. (3)(d) above, the maximum benefit payable shall be \$2,200 during the lifetime of each individual.

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 will not count against the annual benefit limit or the lifetime orthodontic limit. Regular copayments will be required for all such services.

E. Pre-Determination of Benefits

If a course of treatment can reasonably be expected to involve Covered Dental Expenses of \$200 or more, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the prepayment agency(s) or insurance company prior to the commencement of the course of treatment.

The prepayment agency(s) or insurance company will notify the employee and the dentist of the benefits certified as payable based upon such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services, or courses of treatment that may be performed for the dental condition concerned in order to accomplish the desired result. The amount included as certified dental expenses will be the appropriate amount as provided in C. and D, determined in accordance with the limitations set forth in F.

If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the prepayment agency(s) or insurance company reserves the right to make a determination of benefits payable taking into account alternate procedures, services or courses of treatment, based on accepted standards of dental practice. To the extent verification of Covered Dental Expenses cannot reasonably be made by the prepayment agency(s) or insurance company, the benefits for the course of treatment may be for a lesser amount than would otherwise have been payable.

This pre-determination requirement will not apply to courses of treatment under \$200 or to emergency treatment, routine oral examinations, x-rays, prophylaxis and fluoride treatments.

F. Limitations

(1) Restorative:

(a) Gold, baked porcelain restorations, crowns and jackets.

If a tooth can be restored with a material such as amalgam, payment of the applicable percentage of the charge for that procedure will be made toward the charge for another type of restoration selected by the patient and the dentist. The balance of the treatment charge remains the responsibility of the patient.

(b) Reconstruction.

Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and their cost remains the responsibility of the patient.

(2) Prosthodontics:

(a) Partial Dentures.

If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision

appliance that patient and dentist may choose to use, and the balance of the cost remains the responsibility of the patient.

(b) Complete Dentures.

If, in the provision of complete denture services, the patient and dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment and the balance of the cost remains the responsibility of the patient.

(c) Replacement of Existing Dentures.

Replacement of an existing denture will be a Covered Dental Expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a Covered Dental Expense only if at least five (5) years have elapsed since the date of the initial installation of that appliance under this Dental Expense Benefits Program.

(3) Orthodontics:

(a) If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services, to the extent remaining, shall be resumed.

(b) The benefit payment for orthodontic services shall be only for months that coverage is in force.

G. Exclusions

Covered Dental Expenses do not include and no benefits are payable for:

(1) Charges for services for which benefits are otherwise provided for surgical, medical and prescription drug coverage.

(2) Charges for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist.

(3) Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the eight (8) upper and lower anterior teeth.

(4) Charges for services or supplies that are cosmetic in nature, (except as provided in C.(2)(k), including charges for personalization or characterization of dentures.

(5) Charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the individual was not insured for Dental Expense Benefits or which were ordered while the individual was insured for Dental Expense Benefits but are finally installed or delivered to such individual more than sixty (60) days after termination of coverage.

(6) Charges for the replacement of a lost, missing, or stolen prosthetic device.

(7) Charges for failure to keep a scheduled visit with the dentist.

(8) Charges for replacement or repair of an orthodontic appliance.

(9) Charges for services or supplies which are compensable under a Workers' Compensation or Employer's Liability Law.

(10) Charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer.

(11) Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.

(12) Charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist.

(13) Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.

(14) Charges for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.

(15) Charges for services or supplies from any governmental agency which are obtained by the individual without cost by compliance with laws or regulations enacted by any federal, state, municipal

or other governmental body.

(16) Charges for any duplicate prosthetic device or any other duplicate appliance.

(17) Charges for any services to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof.

(18) Charges for the completion of any insurance forms.

(19) Charges for sealants and for oral hygiene and dietary instruction.

(20) Charges for a plaque control program.

(21) Charges for services or supplies related to periodontal splinting.

H. Coordination of Benefits

Coordination of benefits will be administered under the same provisions applicable to the National Account Program hospital, surgical, medical, prescription drug, vision and hearing aid coverages.

I. Reimbursement for Third Party Liability – Subrogation

Reimbursement for Third Party Liability – Subrogation will be administered under the same provisions applicable to the National Account Program hospital, surgical, medical, prescription drug, vision and hearing aid coverages.

J. Proof of Loss

The prepayment agency(s) or insurance company reserves the right at its discretion to accept, or to require verification of, any alleged fact or assertion pertaining to any claim for Dental Expense Benefits. As part of the basis for determining benefits payable, the prepayment agency(s) or insurance company may require x-rays and other appropriate diagnostic and evaluative materials.

K. Administrative Manual

Policies, procedures and interpretations to be used in administering Dental Expense Benefits shall be incorporated in an Administrative Manual. Among other things the Manual shall:

- (1) Explain the benefits and the rules and regulations governing their payment.
- (2) Include standardized administrative practices and interpretations which affect benefits.
- (3) Define professionally recognized standards of practice to be applied to benefits and procedures.
- (4) List the eligibility provisions and limitations and exclusions of the coverage, and procedures for status changes and termination of coverage.
- (5) Provide the basis upon which charges will be paid, including provisions for the benefit payment mechanism and protection of individuals against excess charges.

(6) Provide for cost and quality controls by means of predetermination of procedures and charges, utilization and peer review, clinical post-treatment evaluation and case reviews involving individual considerations of fees or treatment.

L. Denturists

Review by the Company and Union will be given to possible inclusion of treatment by denturists in certain states where they are licensed.

M. Definitions

The term “dentist” means a legally licensed dentist practicing within the scope of his license. As used herein, the term “dentist” also includes a legally licensed physician authorized by his license to perform the particular dental services he has rendered.

The term “reasonable and customary charge” means the actual fee charged by a dentist for a service rendered or supply furnished but only to the extent that the fee is reasonable taking into consideration the following:

(1) The usual fee which the individual dentist most frequently charges the majority of his patients for a service rendered or a supply furnished; and,

(2) The prevailing range of fees (as defined in the National Account Program Administrative Manual) charged in the same area by dentists of similar training and experience for the service rendered or supply furnished; and,

(3) Unusual circumstances or complications requiring additional time, skill, and experience in connection with the particular dental service or procedure.

The term “area” means a metropolitan area, a county or such greater area as is necessary to obtain a representative cross-section of dentists rendering such service or furnishing such supplies.

The term “course of treatment” means a planned program of one or more services or supplies, whether rendered by one or more dentists, for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

The term “orthodontic treatment” means preventive and corrective treatment of all those dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as a result of accidental injury and which require repositioning (except for preventive treatment) of teeth to establish normal occlusion.

The term “ordered” means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays and onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.

Section 7. Vision Expense Benefits

A. Enrollment Classifications

Vision Expense Benefits for an eligible employee or surviving spouse shall include coverage for eligible dependents as they are defined in the National Account Program hospital, surgical, medical and prescription drug coverage.

B. Description of Benefits

Vision Expense Benefits will be payable, subject to the conditions herein, if any covered person, while vision expense coverage is in effect with respect to such covered person, incurs Covered Vision Expense.

C. Definitions

As used herein:

(1) “physician” means any licensed doctor of medicine or osteopathy legally qualified to practice medicine and who within the scope of his license performs vision testing examinations and prescribes lenses to improve visual acuity.

(2) “ophthalmologist” means any licensed doctor of medicine or osteopathy legally qualified to practice medicine, including the diagnosis, treatment, and prescribing of lenses related to conditions of the eye.

(3) “optometrist” means any person licensed to practice optometry in the state in which the service is rendered.

(4) “optician” means any person licensed in the state in which the service is rendered to supply eyeglasses prescribed by a physician or optometrist to improve visual acuity, to grind or mold the lenses or have them ground or molded according to prescription, to fit them into frames and to adjust the frames to fit the face.

(5) “provider” means any of the foregoing.

(6) “participating provider” means a provider that has a written agreement with the Vision Expense Benefits carrier pursuant to which vision examinations, lenses or frames are provided under Vision Expense Benefits in accordance with the terms and conditions stated in the written agreement and to accept as payment therefore the amounts determined in accordance with the written agreement.

(7) “non-participating provider” means an ophthalmologist, optometrist, or optician who has not signed an agreement with the carrier to provide vision examinations, lenses or frames to enrollees.

(8) “reasonable and customary” means the actual amount charged by a provider for a vision examination, lenses or frames, but only to the extent that the amount is reasonable and takes into consideration:

(a) the usual amount that the provider most frequently charges the majority of his patients or customers for the vision examination, lenses or frames provided;

(b) the prevailing range of charges made in the same area by providers of similar training and

experience for the vision examination rendered or lenses or frames furnished; and

(c) unusual circumstances or complications requiring additional time, skill and experience in connection with the particular vision examination rendered or lenses or frames furnished.

As used in the Appendix, “reasonable and customary charge” also refers to scheduled or other contracted amounts of payment used by carriers with participating provider arrangements. The carrier is responsible for determining the appropriate reasonable and customary charge for a given provider and service or material, and such determination shall be conclusive.

(9) “lenses” means ophthalmic corrective lenses, either glass or plastic, ground or molded as prescribed by a physician or optometrist to be fitted into frames.

(10) “contact lenses” means ophthalmic corrective lenses, either glass or plastic, ground or molded as prescribed by a physician or optometrist to be fitted directly to the patient’s eyes. These are subject to limitations and exclusions applicable to lenses generally.

(11) “frames” means standard eyeglass frames into which two lenses are fitted.

(12) “covered person” means the eligible employee, surviving spouse and eligible dependents.

(13) “Covered Vision Expense” means the charges incurred for vision examinations, lenses and frames for such lenses as described below, and

are either for vision examinations, lenses or frames obtained from a participating provider, payable in accordance with D. below or for vision examinations, lenses or frames obtained from a non-participating provider payable in accordance with D. below:

(a) vision examination – performed by a physician or optometrist, including a determination as to the need for correction of visual acuity, prescribing lenses, if needed, and confirming the appropriateness of eyeglasses obtained under the prescription. It shall include: history; testing visual acuity; external examination of the eye; binocular measure; ophthalmoscopic examination; tonometry when indicated; medication for dilating the pupils and desensitizing the eyes for tonometry, if applicable; and summary and findings. If an optometrist as a result of his examination recommends that the covered person be examined by an ophthalmologist with respect to a vision problem, and the ophthalmologist's examination occurs within 60 days of the optometrist's examination, both vision examinations are a Covered Vision Expense;

(b) lenses of a quality equal to the first quality lens series manufactured by American Optical, Bausch and Lomb, Orthogon, Tillyer or Univis, and which meet Z80.1 or Z80.2 standards of the American National Standards Institute, including, when prescribed, equivalent plastic lenses or tints equal to Rose Tints #1 and #2. Lenses not more than 65 millimeters in diameter will be a Covered Vision Expense under Vision Expense Benefits. If lenses are of a quality or size that result in an additional charge, only charges in accordance with D. below shall be payable;

(c) frames adequate to hold lenses which are a Covered Expense; and

(d) contact lenses when the covered person's visual acuity cannot otherwise be corrected to at least 20/70 in the better eye, or when medically necessary due to keratoconus, irregular astigmatism or irregular corneal curvature, or when selected for other reasons, within the limits described in D. below.

(14) "Corrective eye surgery" means a surgical procedure used to alter the cornea or shape/surface of the eye in order to improve visual acuity, correct vision conditions such as myopia, hyperopia or astigmatism and reduce or eliminate the reliance on eyewear. Such surgeries can include, but are not necessarily limited to, Laser-assisted In-Situ Keratomileusis (LASIK), PhotoRefractive Keratectomy (PRK) and Radial Keratotomy (RK).

D. Benefits

Benefits will be provided for covered vision expenses up to a specified amount and are paid differently depending on whether care is received from a participating or non-participating provider. Benefits are reduced if care is received from a non-participating provider.

Benefits will be paid for the covered vision expenses described in 1. 2. and 4. below, less any co-payment as described in 3. below.

Benefit	Frequency	In-Network Co-Pay	In-Network Coverage
Eye Examination	Every 24 months	\$5	Covered in full, includes dilation
Eyeglasses Lenses	Every 24 months	\$7.50	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings (a).
Frames	Every 24 months	\$7.50	Frame allowance: A \$100 retail allowance is provided toward any frame, or a \$150 retail allowance provided towards Featured Frame Brands from participating providers, or a \$150 retail allowance on any frame at Visionworks, plus 20% off the remaining balance. (See below for additional costing (c).
Contact Lenses (in lieu of Eyeglasses)	Every 24 months	\$7.50	Contact Lens Allowance: \$90 retail allowance toward any contacts from participating provider's supply, plus <ul style="list-style-type: none"> ▪ 15% savings on the remaining balance after you use your allowance ▪ 15% savings on a contact lens exam (fitting and evaluation) (See below for additional costing (b).
Medically Necessary Contact Lenses	Every 24 months	\$7.50	Medically Necessary Contacts: One pair from participating provider in full with prior approval.

1. Vision Examinations:

(a) Refraction, including case history, coordinating measurements, and tests;

(b) The prescription of glasses and contact lenses where indicated; and

(c) Examination by an affiliated optometrist or ophthalmologist, upon referral by a network optometrist .

2. Lenses and Frames:

When lenses are prescribed by an ophthalmologist or optometrist, the necessary materials and

professional services connected with the ordering, preparation, fitting, and adjusting of:

(a) Lenses (single vision, lined bifocal, or trifocals). Standard single-vision, lined bifocal, or trifocal lenses are subject to co-payment. Plastic lenses, tinting of plastic lenses, and scratch-resistant coating are provided by participating providers at no cost to the covered person. Additional lens options and coatings are available at discounted prices by participating providers:

Services and Products	Member Cost
Polycarbonate Lenses	\$0-\$30
Standard Anti-Reflective (AR) Coating	\$33
Premium/Custom Anti-Reflective (AR) Coating	\$65-\$85
Photochromic Lenses (i.e. Transitions, etc)	\$70
Ultraviolet Coating	\$10
Near Variable Focus Vision Lenses	\$30
Standard Progressive Addition Lenses	\$0
Premium/Custom Progressive Addition Lenses	\$95-\$175
High-Index Lenses	\$55
Polarized Lenses	\$60

(b) Contact lenses in lieu of glasses. Contact lens, evaluation, fitting and follow up care are provided at a 15% discount for standard contacts and specialty contacts. A \$90 retail allowance is provided toward participating provider supplied contacts lenses, plus 15% off the remaining balance.

(c) Frames. A \$100 retail allowance is provided toward any frame, or a \$150 retail allowance provided towards Featured Frame Brands from participating providers, or a \$150 retail allowance on any frame at Visionworks plus 20% off the remaining balance.

3. Co-payments:

For each covered person, the following co-payments are applicable for the following services and products:

(a) \$5.00 co-payment applicable to the covered vision expenses for each vision examination.

(b) \$7.50 co-payment for the covered vision expenses for eyeglasses lenses or contact lenses.

(c) co-payments may be applicable to various level of frames from the participating providers.

If a covered person chooses lenses or frames costing more than those provided above, or if he requests unusual services from the provider, the covered person shall pay in addition the full additional charge of the participating provider.

4. Other Benefits:

(a) Corrective Eye Surgery. Corrective eye surgery performed by an ophthalmologist will become a covered service as described below. Coverage includes any related pre and post-surgical professional services, facility expense and medically necessary supplies. Coverage is subject to the following provisions:

- (i) A covered person may receive benefits for both corrective eye surgery and for frames and/or lenses (including contact lenses) in the same calendar year;

- (ii) Upon proof of payment to the corrective eye surgery provider, the carrier will reimburse the employee for covered expenses, up to the lesser of the charges or the maximum benefit of \$350 in any four (4) year period; and

(b) Progressive Myopia (rapidly changing near sighted vision): Yearly visual screening with a \$5 co-payment and new lenses, subject to a \$7.50 co-payment with a prescription change of a .50 diopter or more for a frequent children up to their 19th birthday. A letter from the ophthalmologist/optometrist indicating Progressive Myopia must be submitted with the claim form.

(c) Type 1 Diabetics: Insulin-dependent diabetics (Type 1) will be eligible for one eye exam every 12 months with a \$5 co-payment. If the exam reveals a prescription change of .50 diopter or more and/or 10 degrees of axis change or more, new lenses will be provided with a \$7.50 co-payment and applicable member costs according to vision benefits provided by the plan annually. Eligible persons must present a letter from a medical physician stating the person has been diagnosed a Type 1 Diabetic. A new letter will be required for files each time this benefit is used.

5. Vision Network:

(a) The carrier has established a network of participating providers who agree to accept reimbursement according to a schedule for the covered vision services and materials described in this Article III, Section 7.

(b) If a covered person uses a participating provider to obtain the covered services, the carrier will reimburse the provider according to the schedule described in this Article III, Section 7.

6. Out-of-Network:

(a) If services are provided by an Out-of-Network provider, the covered person must pay the nonparticipating provider for all charges and then submit a claim for reimbursement to:

VSP
P.O. Box 495918
Cincinnati, OH 45249-5918

(b) The schedule of reimbursement for Out-of-Network and Out-of-Area is as follows:

(i) Out-of-Network – These Out-of-Network reimbursements are applicable to covered persons who do not have an In-Network Provider within 25 miles of their home address but choose not to use one of them.

**REPRESENTED-OUT-OF-NETWORK
REIMBURSEMENT SCHEDULE**

Eye Examination up to \$29 | Frame up to \$29

Eyeglass Lenses (per pair) up to:

Single Vision \$16

Bifocal \$24

Trifocal \$31

Lenticular \$60

Elective Contacts up to \$38

Medically Necessary Contacts up to \$103

(ii) Out-of-Area – These Out-of-Area reimbursements are applicable to covered persons who do not have an In-Network Provider within 25 miles of their home address.

REPRESENTED-OUT-OF-AREA REIMBURSEMENT SCHEDULE

Eye Examination up to \$39 | Frame up to \$38

Eyeglass Lenses (per pair) up to:

Single Vision \$38, Bifocal \$38, Trifocal \$55

Elective Contacts up to \$55

Medically Necessary Contacts up to \$148

7. Frequency Limitations:

For each covered person, vision care is covered once every other calendar year. The limitations on lenses, contact lenses, and frames apply whether or not they are a replacement of lost, stolen, or broken lenses, contact lenses, or frames.

E. Exclusions and Limitations of Benefits

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter), except as specifically allowed under the Suncare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.

- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

F. Prepaid Group Practice or Alternative Plan Option

The Company will make arrangements for eligible employees, and certain surviving spouses, to be afforded the option to enroll for vision expense coverage under approved and qualified prepaid group practice or alternative option, instead of the vision expense coverage hereunder; provided, however, that the Company's contribution toward coverage under such group practice plans shall not be greater than the amount the Company would have contributed for vision expense coverage hereunder. If the alternative option ceases to be able to provide vision expense benefits, the enrollees therein, if otherwise eligible, will be enrolled for coverage provided in this Section 7.

G. Coordination of Benefits

Benefits will be paid according to the terms of the vision policy, subject to any applicable state or federal codes, statutes or regulations.

H. Reimbursement for Third Party Liability – Subrogation

Reimbursement for Third Party Liability – Subrogation will be administered under the same provisions applicable to the National Account Program hospital, surgical, medical, prescription drug, hearing aid and dental coverages.

I. Administrative Manual

Policies, procedures and interpretations to be used in administering the Vision Expense Benefits Plan shall be incorporated in an Administrative Manual prepared by the Plan Carrier upon review and approval by the Company and the Union.

J. Data

The Control Plan annually shall furnish the Company and the Union such information and data as may be mutually agreed upon by the parties with respect to vision expense coverage.

K. Cost and Quality Controls

The Vision Expense Benefits carriers will each undertake the following review procedures and mechanisms and report annually to the Committee:

(1) Utilization Review

Analysis of various reports displaying such data as provider/patient profiles, procedure profiles, utilization profiles and Covered Vision Expense Benefits payments summaries to:

(a) evaluate the patterns of utilization, cost trends and quality of care;

(b) establish guidelines and norms with respect to profiles of practice in order to identify providers with either a high or low percentage of prescriptions issued in relation to the number of covered persons examined or other departures from the guidelines; and

(c) establish the percentage of Covered Vision Expense Benefits payments that are paid to participating providers.

(2) Price Reviews

Where possible, price reviews or other audit techniques shall be conducted to examine records, invoices and laboratory facilities and materials and to verify that charges for covered persons are the same as for other patients. These examinations may include patient interviews and clinical evaluations of services received.

(3) Evaluation of Services Received

On a random or selective basis, covered persons who have received services under Vision Expense Benefits will be selected for subsequent evaluation and examination by consulting providers to ensure that the services reported were actually provided

and were performed in accordance with accepted professional standards. Such evaluations may include (a) re-examinations to determine the accuracy of the prescription, (b) the quality of lenses and frames, (c) whether the vision testing examinations administered by providers are as comprehensive as contemplated by C.(11)(a) and (d) other aspects of the services provided.

(4) Survey of Services Received

On a random or selective basis, covered persons who have received services under Vision Expense Benefits may be sent a questionnaire to:

(a) determine the level of satisfaction with respect to these services;

(b) determine whether services for which Vision Expense Benefits were paid were actually received;

(c) determine whether providers recommend unnecessary optional services or supplies; and

(d) identify other problem areas.

L. Claims Processing

The Vision Expense Benefits carriers may conduct audits of claims being processed such as an analysis of patient histories and screening for duplicate payments in addition to the normal eligibility, benefit and charge verifications.

M. Peer Review

When the Vision Expense Benefits carriers or a covered person do not agree with the appropriateness

of a charge or service provided under Vision Expense Benefits, an appeal procedure involving peer review may be utilized. Peer review may also be used to resolve situations involving providers with aberrant utilization patterns. The Vision Expense Benefits carriers will seek to establish peer review where it does not exist.

Section 8. Hearing Aid Expense Benefits

A. Enrollment Classifications

Hearing Aid Expense Benefits coverage for an eligible employee or surviving spouse shall include coverage for eligible dependents as they are defined in the National Account Program hospital, surgical, medical and prescription drug coverage.

B. Description of Benefits

Hearing Aid Expense Benefits will be payable, subject to the conditions herein, if any covered person, as defined in C.(11), while hearing aid expense coverage is in effect with respect to such covered person, incurs covered hearing aid expense.

C. Definitions

As used herein:

(1) "physician" means a participating otologist or otolaryngologist who is board certified or eligible for certification in his specialty in compliance with standards established by his respective professional sanctioning body, who is a licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of his license, performs

a medical examination of the ear and determines whether the patient has a loss of hearing acuity and whether the loss can be compensated for by a hearing aid;

(2) “audiologist” means any participating person who (a) possesses a master’s or doctorate degree in audiology or speech pathology from an accredited university, (b) possesses a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association and (c) is qualified in the state in which the service is provided to conduct an audiometric examination and hearing aid evaluation test for the purposes of measuring hearing acuity and determining and prescribing the type of hearing aid that would best improve the covered person’s loss of hearing acuity. Where a physician performs the foregoing services, he shall be deemed an audiologist for purposes of Hearing Aid Expense Benefits.

(3) “dealer” means any participating person or organization that sells hearing aids prescribed by a physician or audiologist to improve hearing acuity in compliance with the laws or regulations governing such sales, if any, of the state in which the hearing aids are sold;

(4) “provider” means a physician, audiologist or dealer;

(5) “participating” means having a written agreement with the Hearing Aid Expense Benefits carrier pursuant to which services or supplies are provided under Hearing Aid Expense Benefits.

(6) “reasonable and customary” means the actual amount charged by a physician or audiologist

for an audiometric examination and a hearing aid evaluation test, but only to the extent that the amount is reasonable and takes into consideration:

(a) the usual amount that the physician or audiologist most frequently charges the majority of his patients for the audiometric examination and hearing aid evaluation test provided;

(b) the prevailing range of charges made in the same geographic area by physicians or audiologists of similar training and experience for the audiometric examination and hearing aid evaluation test provided; and

(c) unusual circumstances or complications requiring additional time, skill or experience in connection with the particular audiometric examination and hearing aid evaluation test provided.

(7) "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 an ear mold, if necessary;

(8) "ear mold" means a device of soft rubber, plastic or a nonallergenic material which may be vented or nonvented that individually is fitted to the external auditory canal and pinna of the patient;

(9) "audiometric examination" means a procedure for measuring hearing acuity that includes tests relating to air conduction, bone conduction, speech reception threshold and speech discrimination;

(10) "hearing aid evaluation test" means a series of subjective and objective tests by which a physician

or audiologist determines which make and model of hearing aid will best compensate for the covered person's loss of hearing acuity and which make and model will therefore be prescribed, and shall include one visit 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;

(11) "covered person" means the eligible employee, eligible surviving spouse and their eligible dependents;

(12) "dispensing fee" means a fee predetermined by the Hearing Aid Expense Benefits carrier to be paid to a dealer for dispensing hearing aids, including the cost of providing ear molds, under Hearing Aid Expense Benefits;

(13) "covered hearing aid expense" means the charges incurred for

(a) audiometric examination performed by a physician or audiologist;

(b) 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; and

(c) hearing aids, but only if (i) the hearing aid is prescribed based upon the most recent audiometric examination and most recent hearing aid evaluation test and (ii) 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 in C.(13)(b) and (c) to be payable as Hearing Aid Expense Benefits, upon each occasion that a covered person receives such services and supplies, the covered person must obtain an audiometric examination that results in a determination that a hearing aid would compensate for the loss of hearing acuity.

D. Benefits

(1) Hearing benefits are covered In-Network at a frequency of once every 36 months as follows:

<u>Service</u>	<u>In-Network</u>
Audiometric Examination	Covered in Full
Hearing Aid Evaluation Test	Covered in Full per ear
Conformity Evaluation	Covered in Full per ear
Digital Hearing Aids	Up to two (2) mid-level standard digital hearing aids will be covered in full, or up to a maximum of \$2,200 toward the purchase of up to (2) upgraded hearing aids.
Dispensing Fee	Covered in Full per ear
Replacement Ear Molds (For children up to age 7)	Up to four (4) replacement ear molds annually are covered in full for children up to age 3. Up to two (2) replacement ear molds annually are covered in full for children ages 3-7. Additional molds are charged to member.

Ear Molds (Enrollees over age 7)	Up to two (2) ear molds covered in Full. Additional molds are charged to member.
Accessories	Not Covered
Maintenance / Fittings / Follow-Up Visits	Covered in Full within 6 months, \$20 copay thereafter

(2) Out-of-Network Benefits

If a covered person lives within 25 miles of a Network provider, a Network provider must be utilized in order to receive coverage. If a covered person lives within 25 miles of a Network provider and receives hearing aid services and materials from a Non-Network provider, there is no coverage. If a covered person lives more than 25 miles from the closest In-Network provider, the member will be reimbursed at the In-Network provider fee level. Preauthorization is required prior to seeking services with a Non-Network provider in order to qualify for reimbursement.

If the covered person requests services beyond the services listed above from the provider, the covered person shall pay the full additional charge therefore.

E. Frequency

If a covered person has received an audiometric examination, a hearing aid evaluation test or a hearing aid for which benefits were payable under Hearing Aid Expense Benefits, benefits will be payable for each subsequent audiometric examination, hearing aid evaluation test or hearing aid only if received more than 36 months after receipt of the most recent previous audiometric examination, hearing aid

evaluation test and hearing aid, respectively, for which benefits were payable under Hearing Aid Expense Benefits.

F. Exclusions

Covered hearing aid expense does not include and no benefits are payable for:

(1) Audiometric examinations for any condition other than loss of hearing acuity;

(2) Medical or surgical treatment;

(3) Drugs or other medication;

(4) Audiometric examinations, hearing aid evaluation tests and hearing aids provided under any applicable workers' compensation law;

(5) Audiometric examinations and hearing aid evaluation tests performed, and hearing aids ordered:

(a) before the covered person became eligible for coverage; or

(b) after termination of coverage;

(6) Hearing aids ordered while covered but delivered more than 60 days after termination of coverage;

(7) Charges for audiometric examinations, hearing aid evaluation tests and hearing aids for which no charge is made to the covered person or for which no charge would be made in the absence of Hearing Aid Expense Benefits coverage;

(8) Charges for audiometric examinations, hearing aid evaluation tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not recommended or approved by the audiologist or physician;

(9) Charges for audiometric examinations, hearing aid evaluation tests and hearing aids that do not meet professionally accepted standards of practice, including charges for any such services or supplies that are experimental in nature;

(10) Charges for audiometric examinations, hearing aid evaluation tests and hearing aids received as a result of ear disease, defect or injury due to an act of war, declared or undeclared;

(11) Charges for audiometric examinations, hearing aid evaluation tests and hearing aids provided by any governmental agency that are obtained by the covered person without cost by compliance with laws or regulations enacted by any federal, state, municipal or other governmental body;

(12) Charges for any audiometric examinations, hearing aid evaluation tests and hearing aids to the extent benefits therefore are payable under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof;

(13) Replacement of hearing aids that are lost or broken unless at the time of such replacement the covered person is otherwise eligible under the frequency limitations set forth herein;

(14) Charges for the completion of any insurance forms;

(15) Persons enrolled in HMO options;

G. Coordination of Benefits

Coordination of benefits will be administered under the same provisions applicable to the National Account Program hospital, surgical, medical, prescription drug, vision and dental coverages.

H. Reimbursement for Third Party Liability – Subrogation

Reimbursement for Third Party Liability – Subrogation will be administered under the same provisions applicable to the National Account Program hospital, surgical, medical, prescription, drug, vision and dental coverages.

I. Administrative Manual

Hearing Aid Expense Benefits policies, procedures and interpretations to be used in administering Hearing Aid Expense Benefits shall be incorporated by the carrier after review and approval by the Company and the Union.

J. Data

The Hearing Aid Expense Benefits carrier annually shall furnish the Company and the Union such information and data as mutually may be agreed upon by the parties with respect to hearing aid expense coverage.

K. Cost and Quality Controls

The Hearing Aid Expense Benefits carrier shall undertake appropriate review procedures to assure a high degree of cost and quality control. Where appropriate, such actions may include utilization review, price review, evaluation of services received and peer review.

October 14, 1996

(A-1) Insurance Coverage While on Union Leave

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

It is agreed that the following procedure will govern continued insurance coverage for employees on Union leave:

An employee on leave to work for the Local Union will be allowed to maintain all his group insurance coverage by paying the contributions outlined in Exhibit B.

An employee on leave to work for the International Union will be allowed to maintain his group life (including survivor income benefits) and accidental death and dismemberment, but not sickness and accident, reinstated sickness and accident or extended disability, insurance coverage by paying the contributions outlined in Exhibit B.

The amount of insurance, established at the onset of the employee's leave to work for the Local Union or the International Union, will be upgraded once each year according to the insurance amounts which would be applicable to his base rate were he working in the plant. The upgrading takes place following contract negotiations, and incorporates any new benefits which may be applicable, and thereafter during the month of December of each year to redetermine the correct amounts of insurance applicable, effective January 1 of the next year, to each such employee.

Very truly yours,

CHRYSLER COMPANY
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Letter Originated - October 23, 1985
John D. Wilson (Corporation)
Marc Stepp (Union)

October 14, 1996

(A-4) Employee Benefit Statement

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

During these negotiations, the Corporation and the Union agreed that the expenses incurred in the development and distribution of the annual Benefit Statement for hourly and salaried UAW represented employees will be paid through Joint Insurance Committee funds described in Letter C-12 of Exhibit B to the Collective Bargaining Agreement.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Up. - October 18, 1993

October 14, 1996

(A-5) Benefit Documents Upon Separation

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

This will confirm our understanding that the Corporation will prepare documents that summarize the Program benefit coverage continuation provisions for employees who are separated from employment due to indefinite layoff, approved sick leave and approved leave of absence. The Corporation will review the documents with the International Union, UAW. The Corporation will make reasonable efforts to make the documents available to

employees who are separated from employment for the reasons stated above. It is understood that the method by which the documents will be made available to employees who are separated may differ from plant to plant depending on the circumstances and the reasons for the employee's separation; and the Corporation is not obligated to distribute the documents to employees. It is further agreed that any such document is intended for informational purposes only and is not a definitive statement of the provisions of any applicable insurance policy or program and that in the event there is a dispute over the interpretation or application of a particular plan or policy the terms of the plan or policy shall be controlling.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Up. – September 18, 1992

October 14, 1996

(B-2) Optional Group Life Insurance Plans - Understandings

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

In response to Corporation concerns regarding local endorsement of optional insurance plans, you have advised the Corporation that local unions will not be authorized to enter into agreements with providers, or endorse or recommend providers, unless the International Union has reviewed them with the Corporation and approved the arrangements.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

October 14, 1996

(B-6) Review of Forms and Procedures

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

This will confirm our understanding with respect to claims procedures under the Program incorporated by reference in the collective bargaining agreements signed today. Any proposed changes in forms or procedures relating to group insurance claims will be reviewed with representatives of the International Union before they are published and implemented.

This will also confirm our understanding that Program employee booklets applicable to employees covered by such collective bargaining agreements will be reviewed with and approved by the International Union before they are published.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Up. - November 1, 1990

Up. - October 25, 1985

October 14, 1996

(B-10) Salary S&A

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

During these negotiations, it was agreed that the Corporation may incorporate the current salary Sickness and Accident benefit payment process into the regular bi-weekly payroll cycle if it determines that doing so will result in a more efficient Sickness and Accident benefit payment system. It is understood any such system would be designed to ensure continued prompt Sickness and Accident benefit payment processing.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Letter Originated - November 19, 1990
John D. Wilson - (Corporation)
Leonard Paula - (Union)

November 20, 2023

(B-13) Abuse of S&A and EDB Programs

International Union, UAW

Attention: Mr. Rich Boyer

Dear Mr. Boyer:

The parties recognize that a relatively small number of Health Care Providers promote overuse and abuse of the Sickness and Accident and Extended Disability Programs primarily by certifying that an employee is totally disabled under certain circumstances

and for periods of time that are generally not consistent or compatible with the total disability certification issued by Health Care Providers generally.

In a joint effort to minimize inappropriate use of the Programs, the UAW International Union, Stellantis Department - Benefits and the Company will meet as needed to develop a list of Health Care Providers who, based on mutually satisfactory criteria, show a pattern of certifying total disability under circumstances that differ noticeably from those that generally appear in the Programs. Certification of total disability from a Health Care Provider on the list approved by the Committee will no longer be regarded as due proof of disability under the Programs. Upon mutual agreement, a Health Care Provider may be added to or deleted from the list. Disability benefits shall not be denied for the reason of proof of disability being submitted by an identified Health Care Provider unless it is established that the employee was previously notified that certification of total disability from a Health Care Provider on the list would not be regarded as due proof of disability.

Very truly yours,

FCA US LLC
By Christopher Fields

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Rich Boyer

November 20, 2023

(B-14) Partial Recovery from Disability

International Union, UAW

Attention: Mr. Rich Boyer

Dear Mr. Boyer:

The parties understand that there are instances where an employee's Health Care Provider releases them to return to full duty work, but it is determined by the Plant Physician that the employee is either not physically qualified to work or requires restrictions. In these instances, the following procedure will apply:

1. If it is determined that the employee's physical condition is such that they are not physically qualified to work, the employee will be instructed to contact their Health Care Provider to provide ongoing Satisfactory Medical Proof of Disability and to contact the Claim Administrator to report their continued off work status. The provisions of Letter B-30 may apply. Sickness and accident benefit payments may resume for the employee provided the employee continues to meet all Eligibility requirements as outlined in Article II, Section 6(A) and pursuant to the benefit duration provisions as outlined in Article II, Section 6(B). If the employee's medical condition improves such that their Health Care Provider provides a new release to return to work, the employee must report to their work site for re-evaluation. All other provisions of the Sickness & Accident program continue to apply to the employee.
2. If it is determined that that the employee's physical condition is such that they require restrictions and the work site provides accommodating work, the employee's eligibility for sickness and accident benefits will end. If the employee's condition subsequently changes such that the employee is not physically qualified to work or requires restrictions and the work site discontinues providing accommodating work, the employee will be directed to follow the process outlined in paragraph 1 above.
3. If it is determined that the employee's physical condition is such that they require restrictions and the work site does not provide accommodating work, the employee will be advised to follow the process as outlined in paragraph 1 above.

Very truly yours,

FCA US LLC
By Christopher Fields

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Rich Boyer

Letter Originated - May 16, 1988
John D. Wilson (Corporation)
Homer Jolly (Union)

December 16, 2019

(B-16) SSDIB

International Union, UAW

Attention: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

It is agreed the following procedure will apply when Social Security Disability Insurance Benefits (SSDIB) are offset from Sickness & Accident (S&A) benefits as provided for in Article II, Section 6.E. of Exhibit B and from Extended Disability Benefits (EDB) as provided for in Article II, Section 8. B. (3) of Exhibit B.

The Insurance Company will assess the employee's case no later than five (5) months from the onset of disability to determine if the employee is a candidate to pursue SSDIB.

Social Security advocates will be used to assist the employee with the SSDIB application process and oversee the progression of the employee's case through to completion. An electronic withdrawal from the employee's bank account (account sweep) shall be utilized by the Social Security advocate as a method to ensure timely recovery of the overpayment associated with a retroactive award of SSDIB.

After an assessment of the employee's case by the Insurance Company, the Insurance Company will provide the employee with a written notice. The written notice will direct the employee to:

1. apply for Social Security Disability Insurance Benefits within forty-five (45) days of the date of the notice; and
2. submit
 - (a) proof of filing for SSDIB;
 - (b) a signed authorization for release of SSDIB information to the Insurance Company;
 - (c) a signed reimbursement agreement; and
 - (d) copies of all Social Security determinations and decisions regarding the SSDIB claim.

The notice will also inform the employee:

1. of the Social Security Disability Insurance Benefits requirements;
2. of the employee's responsibilities for compliance with the application process;
3. that the employee's case has been referred to a Social Security advocate;
4. that a presumed SSDIB offset will apply:
 - (a) effective the first of the month following the forty-five (45) day application period if the employee fails to complete the SSDIB application process; or
 - (b) effective the date of any non-compliance if the employee does not cooperate with the Social Security advocacy process (including agreement to allow an account sweep for purposes of overpayment recovery);
5. that at any time while an S&A or EDB claim is pending, upon request, an employee may be instructed to supply the Insurance Company with a completed authorization for the release of Social Security information and failure to supply the authorization to the Insurance Company within 30 days of the request will result in a presumed offset of SSDIB effective the first of the month following the 30 day period.

In the event of a denial of SSDIB, the employee shall be required to pursue any further action recommended by the Social Security advocate (e.g., reconsideration/appeal; hearing). If at any time the employee does not comply with the Social Security advocacy process, the Insurance Company will reduce the employee's S&A and EDB benefits by the amount of SSDIB for which the employee is presumed to be eligible at the time of non-compliance.

Upon request, an employee may be directed to make a second application for SSDIB. In such cases, all of the provisions of this letter shall apply.

Employees selected to apply for SSDIB who believe they will not be disabled in excess of 12 months may submit a written statement to that effect from their legally licensed physician. The physician statement shall be supplied to the Insurance Company no more than 30 days from the date of the notice directing the

employees to apply for SSDIB. If the information is sufficient and timely, the employee will be exempt from the process. However, the Insurance Company retains the right to direct application for SSDIB at a future date.

Employees who are not selected for SSDIB filing by the Insurance Company shall notify the Insurance Company if an SSDIB application is pursued outside of the Social Security advocacy process. Such employees shall be required to supply the Insurance Company with notice of filing within thirty (30) days of the application and provide the Insurance Company with notification of award/denial within thirty (30) days of the decision. In the event of a denial of SSDIB, the Insurance Company may direct the employee to pursue the appropriate next step in the review process and/or refer the case to a Social Security advocate, the employee is subject to all the provisions of this letter.

In the event of a denial of SSDIB, and provided any subsequent review does not reverse such decision, the employee will not be required to repay any Sickness and Accident (or Extended Disability) benefits otherwise payable, unless such denial of SSDIB resulted from the employee's refusal to accept vocational rehabilitation. Where such denial occurs, the employee shall be obligated to repay Sickness and Accident (and Extended Disability) benefits in an amount equal to the amount of SSDIB to which he would otherwise have been entitled for the same period or periods of disability.

Upon receipt of a notice of award of SSDIB, any overpayment of Sickness and Accident (or Extended Disability) benefits that results from a retroactive award of SSDIB shall be repaid in full to the Insurance Company within thirty (30) days of the award unless other repayment arrangements have previously been approved by the Company. The amount of the overpayment will be based on the actual amount of such award for the coinciding period of Sickness and Accident (or Extended Disability) benefit payments. Failure to repay the full amount of overpayment within thirty (30) days will result in a referral of the overpayment amount to a collection agency, which may result in legal action.

In the event a SSDIB award results from a Reconsideration or Hearing before an administrative law judge, the amount of Sickness and Accident (and Extended Disability) benefits to be repaid will be reduced by an amount equal to any attorney or Social Security advocate fees awarded by the Social Security Administration, provided the employee makes such repayment in full within 30 days of the date the employee is notified of the amount to be repaid. This reduction applies only to attorney or

Social Security advocate fees associated with a successful appeal of a denial of SSDIB and includes only that portion of the attorney's or Social Security advocate fees associated with the period of time the employee was entitled to receive Sickness and Accident (and Extended Disability) benefits. This reduction for such attorney or Social Security advocate fees may not exceed the lesser of either 25 percent of the repayment due or the Company's applicable Social Security advocacy fee in effect at the time of the award. Attorney or Social Security advocate fees for services prior to denial of the initial application for SSDIB will not reduce the amount of any overpayments.

If SSDIB benefits are presumed pursuant to the foregoing provisions and the employee subsequently makes the required filing with Social Security and provides proof of the same to the Insurance Company, the employee will be refunded any benefits presumed on and after the date the required filing was actually made with Social Security. Any benefits presumed prior to the filing date with Social Security will remain offset against the employee's S&A or EDB benefits for the duration of the non-compliance.

In all situations noted in this letter, reminder notices will be sent to employees throughout the claim process to help ensure employees understand their responsibilities in the process.

The benefit presumption described above will only be made in regard to SSDIB benefits and will not apply to Social Security old age benefits.

Very truly yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Cynthia Estrada

December 16, 2019

(B-17) EDB Offset/Pension

International Union, UAW

Attention: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

Article II, Section 8. B. (1) of Exhibit B to the collective bargaining agreements we have just negotiated with you provides that extended disability benefits payable under that Section will be reduced by benefits the employee is eligible to receive under The Pension Plan or any other pension plan or retirement program then in effect to which the Company or any of its subsidiaries has contributed.

This will confirm that notwithstanding the requirement of Article II, Section 8. B. (1), the reduction, to the extent permitted by Section 8. D., for benefits that the employee is eligible to receive under the FCA US LLC Salaried Employees' Retirement Plan will be limited to 80% of the non-actuarially reduced benefits such employee is eligible to receive under the contributory portion of the Plan and 100% of the non-actuarially reduced benefits such employee is eligible to receive under the non-contributory portion of the Plan.

Very truly yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Cynthia Estrada

Letter Originated - December 10, 1982
J. D. Wilson (Corporation)
Robert J. Jensen (Union)

October 14, 1996

(B-18) Workers' Compensation

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

If an employee is disqualified for workers' compensation he will be paid group sickness and accident insurance benefits if he otherwise qualifies for such benefits.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Letter Originated - November 5, 1976
J. William Read (Corporation)
Arthur Hughes (Union)

October 14, 1996

(B-19) Workers' Compensation Attorney Fees

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

During these negotiations, the parties discussed the payment by the Insurance Company of attorney fees from Workers' Compensation amounts allocated to reimbursement of Sickness and Accident and Extended Disability Benefits.

It is the Corporation's policy that neither the Insurance Company nor the Corporation will attempt to recover from an employee whose attorney fees paid by the Insurance Company on

Workers' Compensation amounts allocated to reimbursement for benefits paid.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

December 16, 2019

(B-21) Life and Disability Overpayment Offsets

International Union, UAW

Attention: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

During the course of these negotiations, the parties discussed and agreed that participants who have received overpayments of Life and Disability benefits shall be ineligible to receive certain Pension increases under the FCA US LLC-UAW Pension Agreement. Life and Disability benefit overpayments owed by a participant shall be reduced by an amount equal to the difference between the lump sum and monthly benefit increases that the participant would have received if the participant had not become ineligible for such benefit increases and the lump sum and monthly benefit increases that the participant received.

Very Truly Yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Cynthia Estrada

December 16, 2019

(B-27) Life Insurance Administration Manual

International Union, UAW

Attention: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

This letter confirms that during prior negotiations, the parties agreed to create a Life Insurance Administration Manual which includes, but is not limited to, the following:

- Optional plan coverage schedules
 - including information regarding levels of coverage for which Evidence of Insurability is not required
- Optional plan contribution rates
- Historical letters and documents regarding plan provisions

The manual will be jointly developed by the parties and will be made available to the International Union, UAW.

This letter further confirms that the manual was implemented effective January 1, 2012, and as Optional plan changes occur, the manual will be updated by the Company and provided to the International Union, UAW.

Very truly yours,

FCA US LLC
By: Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By: Cynthia Estrada

December 16, 2019

(B-28) Retiree Group Life Considerations

International Union, UAW

Attention: Mrs. Cynthia Estrada:

Dear Mrs. Estrada:

During these negotiations, the parties discussed the retiree group life insurance provisions included in Exhibit B, The Life, Disability and Health Care Benefits Program.

Retirees age 65 and over are subject to a monthly reduction of 2% of their group life insurance benefit amount until their ultimate life insurance benefit is reached, as determined by the formula provided in Exhibit B. This provides uncertainty for retirees as to the value of their group life insurance. Additionally, the ultimate life amount is reached before age 69 for all retirees, and the average age of death for this group is 78.

The parties further discussed the option of instituting a flat rate retiree life benefit. To this end, the parties may mutually agree during the term of this Agreement to amend the group life insurance benefit available to retirees as permitted by law.

Very truly yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Cynthia Estrada

December 16, 2019

(B-29) Supplemental Employee Optional
Group Life Insurance Considerations

International Union, UAW

Attention: Mrs. Cynthia Estrada:

Dear Mrs. Estrada:

During these negotiations, the parties discussed the feasibility of supplemental employees being allowed the opportunity to participate in the Optional Group Life Insurance program, as outlined in Article II, Section 3 of Exhibit B, The Life, Disability and Health Care Benefits Program.

The parties have agreed that following the close of these negotiations, they will pursue options with the life insurance company to determine if the insurance company can accommodate inclusion of the supplemental employees into the Optional Group Life Insurance program, as noted above, in a fashion which does not increase the Company's administrative costs. If such accommodation can be made, the parties will work together to implement an optional group life benefit offering for the supplemental employees.

Very truly yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Cynthia Estrada

November 20, 2023

(B-30) Employees Released to Return to Work
Who are Physically Disqualified

International Union, UAW

Attention: Mr. Rich Boyer

Dear Mr. Boyer:

During prior negotiations, the parties discussed concerns regarding employees in receipt of Sickness & Accident benefits released by their Health Care Provider to return to full duty work who are disqualified for work by the company physician. Notwithstanding the provisions of Letter B-14 - Partial Recovery from Disability, the following provisions will apply when an employee has been released to return to full duty work by their Health Care Provider.

1. If the employee's treating Health Care Provider releases the employee to return to work without restrictions and the plant physician determines the employee is not physically qualified to return to work in any capacity or requires restrictions and cannot be placed, due to the same condition for which the employee has been disabled, for purposes of Sickness & Accident benefits the plant physician's determination may satisfy the requirement under Article II, Section 6(A) for disability certification for the employee for up to 7 (seven) calendar days following the last day for which the Health Care Provider provided disability certification, and the employee will be eligible for continuing Sickness & Accident benefits provided they otherwise meet the eligibility requirements and subject to the benefit duration provisions as outlined in Article II, Section 6(B).
2. If the employee's absence from work extends beyond 7 (seven) calendar days as noted above in paragraph 1, the employee will be required to provide satisfactory proof of disability certification by their treating Health Care Provider in order to continue to meet the disability certification requirements pursuant to Article II, Section 6(A). With the appropriate consent from the employee, the plant physician will contact the employee's treating Health Care Provider to advise why the determination has been made that the employee is unable to return to full duty work.

3. The provision as noted in paragraph 1 above does not apply to Extended Disability Benefits. If an otherwise eligible employee will reach their maximum Sickness & Accident benefit duration within the noted 7 (seven) calendar day period, the employee must provide disability certification from their own Health Care Provider in order to qualify for the remainder of their Sickness & Accident benefit.

4. The provision as noted in paragraph 1 above does not apply if the condition physically disqualifying the employee from returning to work is not the same condition for which the employee's Health Care Provider has provided a release to return to full duty. If the employee is physically disqualified from returning to work due to a different condition, the employee must provide disability certification from their Health Care Provider which meets the requirements of Article II, Section 6(A) and otherwise meet the eligibility requirements in order to continue to receive Sickness & Accident benefits, subject to the benefit duration provisions of Article II, Section 6(B).

Very truly yours,

FCA US LLC

By: Christopher Fields

Accepted and Approved:

INTERNATIONAL UNION, UAW

By: Rich Boyer

December 16, 2019

(B-31) Long Term Care

International Union, UAW

Attention: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

During these negotiations, the parties discussed voluntary long term care insurance.

The parties agree to explore voluntary long term care insurance offerings, through the Joint Insurance Committee (JIC), over the term of this agreement.

Very truly yours,

FCA US LLC
By: Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By: Cynthia Estrada

December 16, 2019

(B-32) Salaried Bargaining Unit
Optional/Dependent Life Offerings

International Union, UAW

Attention: Mrs. Cynthia Estrada:

Dear Mrs. Estrada:

During these negotiations the parties discussed that the Salaried Bargaining Unit and Salaried non-bargaining employees share the plan offerings for Optional and Dependent Group Life and that these benefit plans are not subject to negotiation between the Company and the Union. This letter will confirm that if the Company is contemplating termination of the Salaried Optional and/or Dependent Group Life plan offerings, the Company will notify the Union before any action is taken.

Very truly yours,

FCA US LLC
By: Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By: Cynthia Estrada

December 16, 2019

(B-33) ADEA Compliance for Life Insurance, AD&D Plans

International Union, UAW

Attention: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

During the course of these negotiations, the parties discussed potential compliance issues regarding the Age Discrimination in Employment Act (ADEA), in both the Group Life and Group Accidental Death and Dismemberment Insurance plans. The parties further agree that should it become known that these insurances are not ADEA compliant, the parties, through the Joint Insurance Committee (JIC), will meet and make the necessary changes to meet ADEA compliance requirements.

Very truly yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Mrs. Cynthia Estrada

November 20, 2023

(B-34) Extended Disability Other Income

International Union, UAW

Attention: Mr. Rich Boyer

Dear Mr. Boyer:

During these negotiations, the parties discussed what constitutes other occupation and income for the purposes of the suspension of benefits pursuant to Article II, Section 8 G. The parties agreed to meet within 90 days following the ratification of this agreement to identify such occupation or income sources to be used for this purpose.

Very truly yours,
FCA US LLC
By: Christopher Fields

Accepted and Approved:

INTERNATIONAL UNION, UAW
By: Rich Boyer

September 29, 2003

(C-1) National Health Insurance

International Union, UAW

Attention: Mr. Nate Gooden

Dear Sirs:

As we discussed during negotiations, national health care reform is an important objective for the Corporation and the Union as well. Consequently, the parties have participated in a number of joint activities at the state level and in Washington. The Corporation and the Union seek to achieve health care reform that will address issues that are important to the welfare of the U.S. auto industry and specifically to the well-being of the Corporation and its employees.

The impact national health reform may have on the Program cannot be predicted with any certainty. Because these matters are unsettled, the Corporation and the Union have agreed to maintain the following understandings regarding national health insurance:

Notwithstanding Article I, Section 1. C. of the Program, if during the term of the Agreements between the Corporation and the Union signed today, any national health insurance act (other than Workers' Compensation or occupational health law), is enacted or amended to provide hospital, surgical, medical, prescription drug, dental, vision or hearing aid benefits for employees, retired employees, surviving spouses and their dependents, which in whole or in part duplicate or may be integrated with the benefits under Exhibit B, the Program, the benefits under Exhibit B shall be modified in whole or in any part, so as to integrate or so as to eliminate any duplication of such benefits with the benefits provided by such federal law.

This integration shall be designed to maintain such integrated benefits as nearly comparable as practicable to the benefits provided in Exhibit B. Such integration shall not result in persons covered under Exhibit B having to pay deductibles or co-payments for benefits under Exhibit B which they would not otherwise pay under Exhibit B.

If any such federal law is enacted or amended, as provided in the paragraph above, the Corporation will pay beginning with the date benefits under such law become available and continuing through (expiration date of Agreements), any premiums, taxes or contributions that employees who are eligible for Corporation paid coverage under Exhibit B may be required to pay under the law for benefits which may be integrated with Exhibit B. This includes payments that are specifically earmarked or designated for the purpose of financing the program of benefits provided by law, in addition to any program of benefits provided by law, in addition to any premiums, taxes or contributions required of the Corporation by law. If such premiums, taxes or contributions are based on wages, the Corporation will pay only the premium, taxes or contributions applicable to wages received from the Corporation.

Any savings realized by the Corporation from integrating or eliminating any duplication of benefits provided under the Program with the benefits provided by law, or any government subsidy paid to the Corporation for providing such benefits, shall be retained by the Corporation.

These understandings are conditioned on the Corporation obtaining and maintaining such governmental approvals as may be required to permit the integration of the benefits provided under the Program with the benefits provided by any such law; otherwise the Corporation and the Union shall meet and develop an acceptable alternative to accomplish the intent of this letter for the remaining term of the Agreements. The parties will meet promptly following the enactment of such legislation in order to assure a smooth implementation of and transition to the integrated program addressed in this letter.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Mark J. Gendregske

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Nate Gooden

September 27, 1999

(C-2) National Health Reform

International Union, UAW

Attention: Mr. Stephen P. Yokich

Dear Sirs:

DaimlerChrysler Corporation and the UAW have long recognized the major problems we jointly confront with the U.S. health care system. The Corporation and the UAW share a serious concern about the high cost and open-ended financing of the health care system and the large number of uninsured. The high cost of health expenditures diverts corporate funds from other business priorities that will enable DaimlerChrysler Corporation to compete more effectively in the market place. Despite the Corporation's and UAW's strenuous efforts to manage our health care programs offered to members of our DaimlerChrysler Corporation family, Corporation health care costs have continued to increase at unacceptable rates. Indeed, the increasing amount of national resources allocated to health care at the expense of other national priorities, adversely impacts the nation's ability to compete with other industrialized countries.

Both DaimlerChrysler Corporation and the UAW share the common objective for a high quality health care delivery system within our nation that is accessible to all and which functions in a cost effective manner. In this regard, DaimlerChrysler Corporation and the UAW jointly agree to support approaches at the federal government level (such as a single-payor system) directed towards achieving prompt and lasting national policy solutions which will assure high quality cost effective care to all individuals. Such approaches should include strong cost containment, equitable financing, and appropriate quality assurance mechanisms and national legal uniformity.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Stephen P. Yokich

September 27, 1999

(C-3) National Health Plan Reform

International Union, UAW

Attn: Mr. Stephen P. Yokich

Dear Sirs:

During these negotiations, the Corporation and the Union discussed initiatives presently under consideration at the federal government level to reform the health care delivery system. The proposed reforms include provisions that would impose, among other things, (i) liability on health care plans, employers, employees, agents and other entities for punitive and compensatory damages arising out of the provision of benefits, (ii) requirements for timely decisions of certain benefit claims, (iii) access to external, independent claim reviews, (iv) access to specialty care, and (v) protections for the provider/patient relationship.

The likelihood of any initiatives becoming law is unknown, and the elements and impact of any legislation cannot be predicted. Nonetheless, the parties agreed that if any national health plan reform legislation is enacted during the term of the agreement, the Corporation and the Union, through the Joint Insurance Committee, will discuss and implement modifications to the Health Care Benefits Program that comply with federal standards as they become effective. The compliance effort will also be undertaken in a manner that achieves the following objectives:

- Minimizes litigation risk to the Program and its fiduciaries.
- Provides greater opportunities for participants to resolve denied claims through Program appeal processes.
- Addresses the legitimate concerns of participants in awareness and understanding of health care issues and benefit terms.
- Corrects any Program terms that constitute unintended violations of new legislation.

The parties agreed to meet during the term of the agreement to discuss the status of proposed federal legislation and take measures consistent with this letter to expeditiously address the mutual objectives of the parties.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Stephen P. Yokich

September 29, 2003

(C-4) Prescription Drug Legislation

International Union, UAW

Attn: Mr. Nate Gooden

Dear Sirs:

During these negotiations, the Corporation and the Union discussed initiatives under consideration at the federal government level to provide prescription drug coverage to eligible recipients of Medicare benefits.

The parties agreed that if any prescription drug benefit initiatives are enacted into federal law during the term of the agreement, the Joint Insurance Committee is authorized to evaluate the impact of the legislation on the Health Care Benefits Program and shall design and implement Program changes to implement the legislation. Implementation of the law shall be accomplished in a manner that promotes the purposes of the Program to make available high quality, cost effective benefits for eligible enrollees.

In particular, the Corporation and the Union recognize and agree that the level of prescription drug benefits provided, inclusive of Medicare-provided prescription drug benefits, shall be approximately equal to the level of benefits now provided in the Program and, to the extent allowed by law, and by mutual agreement with the Union, shall permit the Company to administer the Program as either a primary or a secondary payor of prescription drug benefits.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Mark J. Gendregske

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Nate Gooden

October 22, 2015

(C-8) Wellness Programs

International Union, UAW

Attention: Norwood H. Jewell

Dear Sir:

During these negotiations, the Company and the Union discussed and mutually agreed there are many benefits which can be derived from encouraging employees to lead healthier life styles. Because it is recognized that such efforts can have a positive influence on the quality of life, product produced, absenteeism, health care costs and productivity, the parties agreed Wellness Programs shall be developed which include the following components:

- Health Risk Assessment (including cholesterol & blood pressure screenings) to identify employees' risks and provide motivation to reduce these risks.
- Education to provide employees with basic knowledge and skills needed to make healthy lifestyle changes.
- Maintenance to help combat the widespread problem of relapse and support change by providing ongoing awareness, group involvement and meaningful incentive opportunities.
- Evaluation to identify priority needs, monitor program implementation, measure program effectiveness in reducing risk and obtain information about the overall success of the program.

The parties further agreed:

1. A comprehensive wellness program will be implemented at each plant location with 500 or more active, full-time, on-roll employees. Implementation will occur on a "phased in" schedule with larger locations given priority.
2. To develop a DaimlerChrysler Corporation/UAW National Wellness Program Manual which will be utilized by the Joint Insurance Committee to ensure all health promotion and wellness programs implemented are done so in accordance with explicit and professional standards. The Joint Insurance Committee shall have the sole responsibility for any necessary revisions of the manual so as to describe, implement and maintain local Wellness Programs in a nationally consistent manner.
3. To implement a voluntary disease and chronic management pilot, effective January 1, 2016 or as soon as practicable, designed to improve member health, reduce health risks, and decrease medical costs by engaging members in preventive health and patient outreach programs.

Very truly yours,

FCA US LLC
By Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Norwood H. Jewell

December 16, 2019

(C-9) Benefits Training Program

International Union, UAW

Attention: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

During these negotiations the Company and the Union discussed the need to develop a comprehensive, on-going benefits training program for UAW and management benefit representatives.

The training program will include in-depth benefits training for newly assigned UAW/management benefit representatives and refresher training for current UAW/management benefit representatives.

The parties agree that the benefits training program will be jointly developed by Company and Union staffs and will cover the SUB, Group Life, Disability, Health and Pension benefit programs currently provided to UAW employees. The training contemplated by the parties will be made available at the FCA-UAW Center for Employee Development or a similar venue located in the Auburn Hills, Michigan area. In addition, the parties agree that this training program includes appropriate related computer application training. It is further agreed that the funding for development and delivery of the training program will be provided by the Company.

Very truly yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Cynthia Estrada

September 27, 1999

(C-10) Fertility Services

International Union, UAW

Mr. Stephen P. Yokich

Dear Sirs:

During these negotiations, the Corporation and the Union discussed services designed to assist couples in conceiving and bearing a child and the adequacy of present benefits in light of current and evolving reproductive services technology which may produce better results.

The parties agree that as soon as practicable following the effective date of this Agreement, the Joint Insurance Committee will gather and evaluate data relative to fertility services and determine the feasibility of delivering such services in accordance with the concept described in the attachment hereto. The parties

may consult with experts in the field as they proceed with such investigation, the fees for which will be charged against JIC funds.

Based upon the results of the investigation and analysis, the parties may, upon mutual agreement, decide to implement a pilot to test the validity of the concept.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Stephen P. Yokich

FERTILITY BENEFIT DESIGN AND DELIVERY CONCEPT

The benefit will be designed so that a common treatment approach is achieved. Panel providers will be credentialed who:

- are qualified in their field;
- agree to abide by a consistent treatment regimen in terms of diagnostic tests, drugs, and protocols;
- maintain quality standards; and
- are willing to meet conditions as the parties may require.

Eligibility for services under the fertility benefit may be limited to those received from the panel providers. Once a pregnancy has been confirmed, the patient may continue obstetric services with her regular doctor.

To the extent feasible the benefits may be carved out from all plans and centered in a national reproductive services program and done in concert with the Union and their other employer partners.

The benefits may include, but not necessarily be limited to, counseling, treatment for underlying conditions of sexual dysfunction, diagnostic services, pharmaceuticals, artificial insemination, in vitro fertilization, surgical intervention, cryopreservation, transvaginal ultrasound, and donor gamete. The parties may also consider adopting:

- a set number of cycles for services (because of the declining probability of success).
- a maximum number of transfers per cycle (in order to reduce the likelihood of multiple births).
- a number of episodes of treatment that will be covered under the program or otherwise set a frequency limitation.

November 20, 2023

(C-12) Joint Insurance Committee

International Union, UAW

Attention: Mr. Rich Boyer

Dear Mr. Rich Boyer:

During these negotiations, the parties re-emphasized their commitment through the Joint Insurance Committee to investigate, consider, and upon mutual agreement, engage in activities that may have high potential for cost savings while achieving the maximum coverage and service for the employees covered for health care benefits for the money spent for such protection.

As evidence of their commitment to contain costs under the health care coverage provided, the parties have agreed to a targeted minimum 10% reduction in total health care costs in constant dollars (adjusted for inflation in the economy by the overall CPI). The carriers for health care coverage will assume some financial risk in committing themselves to the achievement of the target and they, in turn, may impose some financial risk on certain providers to help in reaching the goal.

The specific activities of the Committee will include, but are not limited to, the following:

1. The parties agree to continue the employee-funded Dependent Care Assistance Plan administered by the Company. This program will enable active employees to pay for dependent care services using pre-tax dollars.
2. Evaluate and, if mutually acceptable, implement a pilot program wherein the payment for services would be based on the qualifications of the provider in relation to the type of

service provided in order to enhance the quality of care and more effectively manage utilization.

3. Develop and where appropriate, upon mutual agreement, implement specialty PPO programs including but not limited to home health care services, dermatological services, diagnostic imaging (including mammography screening), cardiac care, and ophthalmological surgery the purpose of which is to deliver high-quality services in a cost-effective manner.
4. Review the circumstances surrounding the medically necessary use of general anesthesia for teeth extractions to determine the appropriateness of expanding applicable coverage.
5. Explore and implement, upon mutual agreement, dental programs based upon a dental preferred provider organization or dental maintenance organization concept including exploring the feasibility of implementing a pilot program that would encourage employees to achieve and maintain dental wellness.
6. Review and monitor dental maintenance organizations to ensure they maintain standards for coverage and quality equal to generally accepted national standards.
7. Engage in efforts to increase enrollee awareness of the positive impacts of coordination of benefits and subrogation provisions to assist in effective and expeditious carrier implementation of programs to emphasize cost avoidance.
8. Conduct a review of various programs, including but not limited to, PPOs with respect to the adequacy of their service areas, hospital predetermination program, Vision program, United Concordia, and the organ transplant program and implement mutually agreeable solutions to any problems identified.
9. Work with carriers to develop and implement pilot programs based on findings of detailed medical review of coverages provided under the Program.
- An effort will be made to identify objective standards which Program carriers can apply uniformly in evaluating quality and appropriateness of such items as inpatient and outpatient surgical and diagnostic procedures and inpatient admissions, medical necessity for various services and supplies, and

overall utilization. Such standards will be utilized to review and analyze local practice patterns.

- An evaluation will be made of current utilization review programs and focused utilization review and other review formats that take into account various hospital reimbursement methodologies (such as the new Blue Cross-Blue Shield of Michigan Hospital Agreements). Consideration will be given to revising the existing predetermination process with the objective of enhancing efficiency and effectiveness, taking into consideration new information, practice patterns and technological advances, prior experience, and new utilization review programs and reimbursement methods.
 - The appropriateness of retaining independent third-party utilization managers/utilization reviewers will be evaluated.
10. Work to improve existing programs or, upon mutual agreement, to develop more effective managed care plans including but not limited to health maintenance organization and preferred provider organization options, for employees both Medicare and non-Medicare. Review the methodology for establishing the Monthly Premium Calculation outlined in Letter C-14 for its adequacy in accounting for differences attributable to gender, age, risk and health status within the enrolled population; and quality and cost effectiveness standards with the Local or competing alternative plans meeting the criteria and benefits established by the parties. Any reviews undertaken by the parties should be timed so that, should the parties mutually agree upon any changes, they may be implemented in time for that year's open enrollment period.
 11. Support Corporate audits of the dependents where abuse of the eligibility provisions may occur. The intent of such audits will be to ensure that those entitled to coverage are enrolled, and that the Program provisions are not being utilized to transfer to the Program the responsibilities of other parties.
 12. Review the issues surrounding treatment of Temporomandibular Joint Syndrome (TMJS) dysfunction and the relationship to current Program coverages. Consider Program adjustments which may be appropriate.
 13. Explore pilot programs, individually or in concert with other payors, to develop relationships with high quality, cost-effective providers and to encourage enrollee use of such providers.

14. Develop and if appropriate implement a certified nurse midwifery pilot program in Michigan which will include well-woman gynecologic and maternity care. In addition, consider the appropriateness of birthing centers as a place for delivery.
15. Gather and evaluate data and upon mutual agreement implement Program specifications that would provide a benefit for services related to allergy testing and dental implants.
16. Review the existing cardiac rehabilitation pilot programs to evaluate the cost effectiveness of the programs and the potential for expansion to additional areas.
17. Review and discuss the present philosophies associated with the existing maintenance drug list to be sure the list is reflective of quality, cost effective prescribing patterns. Consider adjustments to the list which may be appropriate.
18. Develop improved communication techniques to advise covered persons about the location of approved physical therapy facilities.
19. Develop and implement by mutual agreement a program to have HMOs and PPOs communicate patient advocacy programs to enrollees. The intent of the parties is to have carriers develop and distribute informational materials through direct mailings or otherwise about how members may: obtain coverage and receive care; gain access to other plan services, including referrals outside the plan network; and register complaints and utilize the grievance process. The parties intend that the carriers will make the information available beginning March 1, 1997, and the parties will recommend standard formats for providing it. The parties can take such mutually agreed upon steps as they deem appropriate (including termination of the carrier offering) should a carrier refuse to comply.
20. Increase the accountability for quality of care by alternative health care plans by monitoring the alternative plans receiving provisional accreditation from the mutually agreed to accrediting agencies to ensure they seek to attain higher accreditation.
21. Determine the feasibility of including treatment for substance use disorder or mental health problems in half-way houses. Implement half-way house coverages in HMOs as practical

provided such may be done without material increase in the cost of HMOs.

22. Evaluate the feasibility of utilizing health care benefit mechanisms (e.g. claim payment arrangements, provider networks, quality and outcome management tools, etc.) to more effectively treat employees' occupational injuries or illness without restricting the employees' existing rights.
23. Explore the feasibility and merits of developing a physical therapy rehabilitation pilot program at a Company location(s) or at external location(s) in close proximity to such plant(s) which would focus on work conditioning, work readiness, and back care programs and provide the equipment and professional personnel necessary to achieve optimum rehabilitation results as determined by the Joint Insurance Committee, funded by the Company.
24. Investigate and if mutually agreed to by the parties, implement managed health care plans in those service areas where alternative plans are not presently available and in areas in which only one alternative plan is currently available.
25. The parties agree to explore effective ways of involving patients in treatment decisions, including but not limited to the use of interactive shared decision-making tools and to implement one or more pilot programs as mutually agreed to by the parties. In addition, the parties will decide upon appropriate contractual requirements for HMO's in order to achieve similar desirable results.
26. The parties agree to evaluate the quality of the mental health and substance use disorder services provided by our HMO's and if appropriate, carve out mental health/substance abuse services from non-performing plans.
27. Evaluate and implement initiatives for specialty medications by July 1, 2008 or as soon as practicable. These initiatives will include, but are not limited to, a specialty drug retail network, specialty mail network and Rx Tools. Such a program would address limits on quality at retail and mail order for enrollees initiating treatment. Additionally, mechanisms will be implemented that ensure appropriate use and dispensing as indicated by the FDA guidelines.
28. Gather and evaluate data relative to new procedures for early detection of diseases or routine screening for conditions to determine the viability of incorporating such procedures into

the Standard plan as they are recommended by public health and/or medical professionals. This process also would allow for the review of a mechanism to automatically update newly covered services as such emerge from experimental status.

29. Explore non-traditional services that would assist in the management of serious health conditions including treatment that can alleviate chronic debilitating pain and alternative treatment modalities which will enhance recovery during an inpatient admission.
30. Develop and issue a Request For Information (RFI) to address patients' interests in obtaining end of life care as an alternative to medical modalities provided by traditional hospitals or other facilities precedent to hospice care. In addition, the parties will re-evaluate our existing hospice program and determine whether an integrated approach is feasible.
31. The parties agree to review the appropriateness and adequacy of the hearing benefit, given the technical and other changes in the audiometric field since its implementation (Article III Section 8).
32. The parties agree to review the current program administration of injectables including the reimbursement methodology.
33. The parties discussed care management and the importance of providing evidence based programs to address the needs of the members in a quality and cost-effective manner. After these discussions the parties reached an agreement to further evaluate, through the JIC, a population-health based care management program and the various features to be incorporated into such program. The parties also agreed that the participation rates in the current programs were low and certain aspects of the new program would need to be structured to increase the participation rate.

Program components may include, but not be limited to a) health promotion support – general health education; b) web-based health management tools; c) shared decision making; d) disease management for chronic conditions; e) case management; f) complex case management; g) health risk assessments and h) biometric screening. The care management program may be aligned with the worksite wellness program.

34. The parties will explore, with other large purchasers, piloting Ambulatory Intensive Care Units (AICUs), with a target pilot implementation in the first quarter of 2013.

35. The parties will evaluate the merits of approved medical practice regarding the diagnosis and treatment of gambling addiction and, if warranted upon mutual agreement, consider inclusion into the mental health and substance use disorder program.
36. The parties reorganized Exhibit B solely as a means to simplify and clarify the Program documents in terms of administrative and “housekeeping” matters. Our objective was to facilitate Exhibit B for its intended purpose and does not alter any of the substantive provisions of the Program.
37. The parties discussed the value of the FCA Family Health Center and the positive effect on the health and well being of employees and their families. All employees will have access to service at the FCA Family Health and Wellness Center (“FHWC”). Currently, there is a FHWC located in Kokomo, with additional clinics planned to be opened in Detroit and Belvidere. The FHWC will provide certain preventative health services and screening, chronic disease monitoring, urgent care services, as well as select prescription services. The parties will work together to encourage employees and their eligible dependents to utilize on-site FHWC services.
38. During the first quarter of 2020, the parties agreed to discuss and identify solutions to the impact of coordination of benefits between FCA health care insurance and an enrollee’s personal automobile insurance.

As indicated above, the parties fully support all programs and activities which enhance the quality and delivery of care, and at the same time, achieve the goals of cost effectiveness. To facilitate the mutually agreed-upon research and evaluation efforts of the parties with respect to the above commitments, the Company agrees to make available \$600,000 during the term of this Agreement.

39. Effective January 1, 2024, or as soon as practicable thereafter, the parties agree to implement, as a pilot program, the Specialty Prescription Drug Program. This pilot Program is offered to the Company through the Pharmacy Benefit Manager (PBM) and will be in effect only as long as it continues to be offered to the Company through the PBM. This pilot Program has an approved list of Specialty Prescription Drugs that, when filled through the PBM’s specialty pharmacy by an enrolled member, have a \$0 member copayment. Although this is a voluntary Program, eligible members are automatically enrolled in the Program.

The approved list of specialty prescription drugs may change from time to time solely at the discretion of the PBM.

For specialty prescription drugs that are not on the approved list, and are filled through the PBM's specialty pharmacy, the member's coinsurance is 30% up to the maximum copayments described in Exhibit B, Article III, Section 3, A. 1(b) (i) and (ii). If a member dis-enrolls from this Program, that member's coinsurance is 30%.

40. Effective January 1, 2024, for eligible members enrolled under the Standard Care Network (SCN) or PPO option, prescription medications only may be filled at a Pharmacy Benefit Manager-owned (PBM) pharmacy so long as the member's home address zip code is within a 5-mile radius of a PBM-owned pharmacy. If the member's home address zip code is outside of a 5-mile radius of a PBM-owned pharmacy, such prescription drug(s) may be filled at any in-network pharmacy.

Very truly yours,

FCA US LLC
By Christopher Fields

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Rich Boyer

October 14, 1996

(C-13) Administrative Fees

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

During the course of these negotiations, the parties discussed, at length, the competitive disadvantage facing Chrysler Corporation associated with the high cost of providing health care benefits to its employees, retirees, surviving spouses and their eligible dependents and the obstacle it poses to the achievement of our common goal of securing the jobs of our employees.

The parties recognize the very significant amount paid in administrative fees to the carriers and third party administrators of the plan and the importance that such administrators be cost conscious and efficient in the performance of their duties and competitive in their administrative charges to Chrysler Corporation.

Accordingly, consistent with our mutual goal to identify and remove all unnecessary costs in the Health Care Plan while maintaining the negotiated level of benefits and improving the quality of care, the parties agree to take appropriate action to obtain a reduction in administrative fees in those situations where such fees are considered excessive, unreasonable or uncompetitive.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Letter Originated - November 19, 1990
John D. Wilson (Corporation)
Leonard J. Paula (Union)

December 16, 2019

(C-14) Monthly Premium Calculation

International Union, UAW

Attention: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

In calculating the Company's monthly contributions (and any required member contributions) under Article III, Section 3. of the Program toward the cost of coverage for eligible members subscribing to a health maintenance organization or an alternative (health delivery) plan, the following method will be used:

1. At the time of any change in the component premium rates (e.g., single, two-party, family) of either an alternative plan or the corresponding local plan, the alternative plan composite

premium shall be compared to an adjusted local plan composite premium developed by using comparable local plan component rates and the alternative plan enrollment mix of Company employees who are then members of the alternative plan. If less than 30 employees of FCA US LLC are then members of the alternative plan (which includes all new alternative plans), the national enrollment mix of all FCA US LLC employees who are enrolled in alternative plans will be used in calculating its composite premium rate and comparing its rate to that of the corresponding local plan so as to produce more reasonable statistical results. Whenever possible, these calculations will employ separate enrollment mixes for FCA US LLC hourly-rate and salaried employee groups, respectively.

2. If the adjusted local plan composite premium is in excess of the alternative plan composite premium, the Company shall pay the full premiums of eligible members subscribing to the alternative plan. See Example #1 on the attachment.
3. If the alternative plan composite premium is in excess of the adjusted local plan composite premium, the Company contribution on behalf of an eligible member enrolled in such alternative plan shall be limited to the amount obtained by multiplying the amount of the applicable component premium rate for the alternative plan by the ratio derived from the adjusted local plan composite premium divided by the alternative plan composite premium. The alternative plan member contribution amount shall be the difference between the appropriate alternative plan component rate less the applicable Company contribution. See Example #2.

Additionally, the parties confirm that the Joint Insurance Committee (JIC) shall be responsible for evaluation and implementing such actions deemed necessary to eliminate the identified excess costs, if any. Such consideration may include:

- HMO Prescription drug co-pay increase
- HMO office visit increase
- Other benefit plan design changes the parties may deem appropriate
- Plan terminations

Separate and distinct from the actions required to eliminate the excess costs, the JIC may also discuss:

- Improving reliability and validity of data for accurate comparison across plan types
- An ongoing adjustment and calculation for changes in health care, finances, delivery, resource utilization and clinical decision-making

We also discussed the formula and agreed to consider adjusting for age, gender and contract size. In addition, we agreed the JIC will study the possibility of including health status or disease burden in the calculation.

Very truly yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
Cynthia Estrada

Attachment

Example #1	Enrollment Mix	Alternative Plan Monthly Rates*	Local Plan Monthly Rates*
Single	16%	\$ 35.00	\$ 30.00
Two-Party	23%	75.00	70.00
Family	61%	100.00	110.00
Composite		\$ 83.85	\$ 88.00

The adjusted local plan composite rate of \$88.00 is in excess of the alternative plan composite premium of \$83.85. Therefore, even though the alternative plan single and two-party component rates exceed those of the local plan, the Corporation will pay the full premiums of all members enrolled in the alternative plan.

Example #2

Single	16%	\$ 35.00	\$ 30.00
Two-Party	23%	75.00	60.00
Family	61%	100.00	100.00
Composite		\$ 83.85	\$ 79.60

The alternative plan composite premium of \$83.85 is in excess of the adjusted local plan composite premium of \$79.60. Shown below is the calculation of the Corporation's and subscriber's contribution toward payment of the alternative plan premiums.

Alternative plan composite rate: \$83.85

Adjusted local plan composite rate: \$79.60

Ratio of the adjusted local plan composite premium to the alternative plan composite premium:

\$79.60 divided by \$83.85 = .949

Corporation and member monthly liability:

Alternative Components	Rates*	Corporation Liability (Component x .949)	Member Liability
Single	\$35.00	x .949 = \$33.22	\$1.78
Two-Party	75.00	x .949 = 71.18	3.28
Family	100.00	x .949 = 94.90	5.10

*The calculation of Company and member liability would be based on each specific alternative plan component rate.

October 14, 1996

(C-15) Plan Financing

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

During these negotiations, the parties agreed to continue the understanding whereby the Corporation could, at its option, finance health care benefits, including dental, through an insured plan, a prepaid capitation program, or an administrative services contract, or any other funding arrangements deemed appropriate. It was further agreed regarding the change in financing arrangements, that the Corporation would:

- Provide that all carriers or administrators who administer the Company's Self-Insurance or Administrative Services Contract arrangement will provide the same group conversion privileges offered under the insured program;

- Pay to BCBSM or any other participating local plan or carrier that administers benefit programs under a Self-Insured or Administrative Services Contract arrangement, the same "social subsidy" or community charge level (including, but not limited to, conversion privilege charge or other-than-group subsidy) that it would pay as a purchaser of insured programs; and
- Reimburse claims and payments of benefits on the same timely basis as with insured plans so as not to negatively affect the delivery of benefits.

In addition, it was understood that the level, scope and delivery of benefits would not be altered as a result of changing from an insured plan to an administrative services contract or self-insurance arrangement.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Letter Originated - October 18, 1993
John D. Wilson (Corporation)
Leonard J. Paula (Union)
Up. - October 23, 1985

October 14, 1996

(C-16) Carrier Administration

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

During present negotiations, the Corporation and the Union discussed the feasibility of pursuing competitive bids related to the administration of the Program with the objective of improving the quality of Program administration, reducing administrative costs,

promoting practices which lower claims costs, and improving customer service. The Union stated that, alternatively, it would be more appropriate to develop and implement performance standards that would enhance the present carriers' performance and cost effectiveness.

We agree that as soon as practicable after the conclusion of the present negotiations, the Joint Insurance Committee, as described in Article I, Section 4. B. of the Program, will meet to discuss the establishment of such performance standards. The standards will be designed to encourage carriers to achieve a higher level of administrative performance in such areas as claims management, employee/retiree servicing, record keeping, reporting capability, cost containment programs administration, data processing, and overall cost effectiveness.

If it is determined after an appropriate period of time that certain carriers are not meeting the agreed-upon performance standards, the Joint Insurance Committee will consider requesting competitive bids for the services provided by those carriers with poor performance. Following receipt of the competitive bids, the Joint Insurance Committee will review the proposals and jointly determine the course of action to be taken.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Letter Originated – October 18, 1993
John D. Wilson (Corporation)
Leonard J. Paula (Union)

December 16, 2019

(C-18) Carrier Data Reports

International Union, UAW

Attention: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

The Company will annually furnish the Union with the preceding calendar year FCA US LLC Health Care data (either directly or through requests to the appropriate carriers) for employees and retirees represented by the UAW

Very truly yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Cynthia Estrada

October 22, 2015

(C-19) Predetermination Program

International Union, UAW

Attention: Mr. Norwood H. Jewell

Dear Sir:

During these negotiations the parties agreed to continue the Predetermination Program for hospital admissions for FCA US LLC-UAW members in all Blue Cross and Blue Shield or another carrier insurance plan areas in accordance with the following administrative conditions:

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, or another carrier as the Control Plan will administer the Predetermination Program nationwide for all local plans. The Control Plan will be responsible for all Predetermination Review. In addition, the administrator will make recommendations to the

parties in the event changes in process or software systems are available to enhance and/or improve the Predetermination Program. The parties will jointly determine the merits of implementing the administrator's recommendations.

Very truly yours,

FCA US LLC
By Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Norwood H. Jewell

December 16, 2019

(C-20) Confidentiality of Medical Information

International Union, UAW

Attn: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

During these negotiations, the Company and the Union agreed on the desirability of maintaining a set of principles concerning the confidentiality of medical information. FCA US LLC will comply with the law which provides protection to employees regarding privacy of protected health information under the Health Insurance Portability and Accountability Act (HIPAA). The Company reviewed with the Union its processes and practices in this regard. The parties acknowledged that medical information means any record, written or electronic, identifying a participant in the FCA US LLC-UAW Pension Agreement or the Life, Disability and Health Care Benefits Program (collectively, "Benefits Programs"), containing diagnostic or treatment information and used in connection with the administration of the Benefits Programs. Accordingly, the following are understood:

- Participants in the Benefits Programs have a legitimate interest in the confidentiality of medical information pertaining to them.
- The Company, third party administrators, and other parties acting on behalf of the Company or third party administrators

in connection with the Benefits Programs (“Other Parties”), have a legitimate need to collect, maintain, and use medical information in the course of performing administrative and other fiduciary functions required by the Benefits Programs and the law (e.g., verifying eligibility and benefit status, claims adjudication, audits for payment purposes, case management, coordination of benefits).

- The Company, third party administrators and Other Parties have a legitimate need to collect, maintain and use aggregate medical information for purposes of analysis, evaluation, oversight and quality control.
- In addition to applicable legal requirements, access to medical information maintained by the Company, third party administrators and Other Parties will be limited to persons having a need to use the information in the course of performing their job duties, and where appropriate and feasible, narrowly tailored in terms of scope and detail to achieve intended business purposes. Aggregate data and/ or summaries will be used by the Company to the extent feasible.
- Medical information exchanged with Other Parties for analysis and evaluation will be used and maintained only for the purpose for which it is provided and not redisclosed by Other Parties without the prior consent of the Company and the Union.
- The Company will establish internal safeguards concerning the exchange of medical information by the Company. Employees who inappropriately exchange medical information will be subject to disciplinary action. The Company will also require third party administrators and Other Parties to establish and enforce policies and procedures consistent with this letter.
- Medical information may be exchanged with Other Parties for clinical, public health and academic research only if a meaningful purpose is to benefit participants in the Benefits Programs. Absent such purpose, the prior agreement of the Company and Union on all aspects of the research (e.g., topics, selection of researchers, distribution of results) is required.

The Company, in consultation with the Union, is committed to continuing its development of processes and practices regulating the use of medical information within the Company and by third party administrators and Other Parties. The Company and the Union also discussed proposed federal legislation and the

possibility of new regulations addressing specific uses of medical information. In the event that federal standards are adopted, the parties will meet to discuss plans for compliance. Should issues arise during the course of the agreement concerning the confidentiality of medical information, the Company will meet with the Union to discuss mutually agreeable solutions.

Very truly yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Cynthia Estrada

October 14, 1996

(C-21) Spousal/Dependent Employment Information

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

During these negotiations, the parties discussed the fact that whenever working spouses of employees and retirees covered under the Corporation's Health Care Benefit Program do not enroll in coverages offered by the spouses' employer, the Corporation is subsidizing the health care costs of such employers. The parties agreed that it is not in their best interest to allow such subsidy to continue. Consequently, it is agreed that the Joint Insurance Committee will, during the first year of the Agreement, work with the Control Plan and other carriers to (a) actively pursue accurate and complete information regarding spousal employment, (b) develop policies and procedures to assist in the collection of this information and (c) require compliance with such policies and procedures by each carrier.

The Joint Insurance Committee will coordinate with the Control Plan on the development and mailing of a Joint Insurance Committee survey document designed to obtain spousal employment and health care eligibility information for all employees and retirees.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Letter Originated - October 18, 1993
John D. Wilson (Corporation)
Leonard J. Paula (Union)
Up. - May 16, 1988

October 12, 2011

(C-23) Experimental/Research Benefit
Exclusion Under the Hospital-Surgical-
Medical-Drug-Dental-Vision-Hearing Program

International Union, UAW

Attention: Mr. General Holiefield

Dear Sirs:

During these negotiations, the parties discussed the longstanding provision under the Program excluding research or experimental care, services or drug therapies from Standard Care Network coverage. The National Account Program, as specified in Article III, Section 4. (which sets forth the hospital-surgical-medical-drug expense benefits negotiated by the Corporation and the Union) states, "benefits are not provided for care, services, supplies, or devices which are experimental or research in nature."

This letter will confirm that the parties have agreed, in the Joint Insurance Committee, to identify and develop special claims procedures (other than or in addition to the claims procedures under the Program) to be followed in the event the local carrier's denial of coverage on such grounds is properly appealed.

Specific modifications to the Program, as recommended by the Joint Insurance Committee, shall be incorporated into the Collective Bargaining Agreement.

The parties have agreed to both an interim appeals procedure as well as a standard of review, which will be applicable in the event that the local carrier receives an appeal, as described in Exhibit B of the Agreement, of a final determination of a claim denied on the grounds that the requested service care or drug therapy is experimental or research in nature. Notwithstanding the appeal provisions set forth in Exhibit B, the claim, along with relevant medical records, will be forwarded by the local carrier to an independent appeals panel of three physicians who are recognized experts in the specialty at issue in the claim. In recognition of the importance of maintaining the objectivity of the appeal process, panel participants will be selected by parties independent of the Company, the Union and the local carrier.

At Company expense, the panel will review the claim and, applying the standard of generally accepted medical practice, will determine whether the care or service is experimental or research in nature in the individual case under appeal. Appeals for services already performed must be made within 6 months of the local carrier's denial, if it was reasonably possible to make such appeal within such time, and will be reviewed on the basis of generally accepted medical practice as of the date on which the service was performed. If at least two out of the three physicians on the panel concur on a decision, that shall be the determination of the panel. The panel's decision shall be the final determination under the Program and shall be binding on all of the parties. However, a procedure not yet performed that already has been determined to be experimental by the appeals panel may be submitted to the local carrier for reconsideration, but only on the basis of new and relevant medical or technological developments that have occurred since the date of the prior review.

Very truly yours,

CHRYSLER GROUP LLC
By Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By General Holiefield

Letter Originated – October 18, 1993
John D. Wilson (Corporation)
Leonard J. Paula (Union)

October 22, 2015

(C-25) Coordinated Care Management Program

International Union, UAW

Attn: Mr. Norwood H. Jewell

Dear Sir:

During these negotiations, the Company and the Union discussed health care management and the importance of providing quality health care in a cost-effective manner. These discussions included the Coordinated Care Management (CCM) program.

The Company and Union reviewed experience to-date under the CCM program as evaluated by a mutually acceptable independent entity and agreed to continue the CCM program. The Parties further agreed that BCBSM or another carrier would continue to report on a quarterly basis to the parties the cost and effectiveness of the CCM program. In addition, detailed program studies and recommendations by a mutually agreeable independent external entity will be completed at the end of each calendar year during the term of the collective bargaining agreement. These examinations of CCM program performance will focus on commitment to quality, improved care and cost effectiveness.

The first detailed program study, to be completed during the first full calendar year of this agreement, will determine whether the clinical, cost and health status improvements of CCM participants are statistically significant due to CCM program interventions. Following the study, the Company and the Union, through the Joint Insurance Committee, will decide whether the CCM program should be modified to help achieve the objective of providing quality health care in a cost-effective manner. Modifications to the CCM program will be implemented as soon as practicable. In addition, the Joint Insurance Committee may jointly decide whether the CCM program will be expanded to include other possible diagnoses with initial consideration being given to low back pain.

Alternatively, if the study determines that the clinical, cost and health status of CCM participants are not statistically significant due to CCM program interventions, the Joint Insurance Committee will decide whether the program will be restructured by the current administrator for a trial period or turned over to another third party administrator. If restructured and positive improvements are not

evident within twelve months from the date of restructure, the program may be turned over to another third party administrator or suspended as determined by the parties.

Very truly yours,

FCA US LLC
By Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Norwood H. Jewell

September 29, 2003

(C-26) Coordination of Benefits

International Union, UAW

Attention: Mr. Nate Gooden

Dear Sirs:

During these negotiations, the Corporation and the Union discussed those Coordination of Benefits provisions in the National Account Program Administrative Manual which are intended to prevent duplicate benefit payments when an individual is covered under more than one health care plan and to provide for recovery rights from other available coverages. The parties agreed to amend the Administrative Manual according to the following guidelines:

1. General Provisions

Health care benefits paid under this Program shall not duplicate benefits from other sources, (e.g., group plans, comprehensive plans, pre-paid plans, governmental plans, etc.), nor serve to relieve other persons or organizations of their liability (contractual or otherwise). Consistent with these objectives, the Corporation may establish systems and procedures for coordination of benefits, and the carriers shall implement such systems and procedures.

2. Applicability

These Coordination of Benefit (COB) provisions shall apply to all coverages provided under the Program. Unless precluded by

law, these provisions apply whether the coverage is self-funded, or provided through pre-paid options such as health maintenance organizations.

- (a) Benefits payable under the Program will be coordinated with and secondary to benefits provided or required by any group or individual automobile, homeowner's or premises insurance, including medical payments, personal injury protection, or no-fault coverage. Coordination by the Program shall be contingent upon the enrollee having first right of recovery from any such no-fault coverage available.
- (b) These COB provisions shall not apply to expenses for services provided to or for an enrollee in relation to any condition, disease, illness or injury arising out of or in the course of employment, as such expenses are specifically excluded from the Program.
- (c) These COB provisions shall not apply to federal or state Medicare or Medicaid. However, they do apply to complementary coverage carried to supplement benefits available under such federal or state programs.

3. Enrollee Obligations

Enrollees shall furnish to the Corporation the social security numbers of all eligible dependents for whom they are claiming eligibility and/or for whom they are required to provide a social security number to claim an exemption on their Federal income tax return. If the dependent has not been assigned a social security number at the time of enrollment, a social security number shall be obtained promptly and reported to the Corporation. Failure to do so shall result in cancellation of coverages for such dependent.

- (a) Any enrollee claiming benefits under this Program shall furnish the Corporation or the carrier(s) any information necessary for the purpose of administering these provisions.

4. Release of Information

The Corporation or carriers may release to other employers or carriers information necessary to adjudicate claims under these provisions.

- (a) The Corporation or carriers under this Program may participate in organizations which are established

to facilitate the COB process and may exchange information relating to enrollees for such purposes.

- (b) Such organizations must agree not to release any information obtained other than for the Purpose of effectuating COB.

5. Determining Priority

- (a) The program which, under the rules of this subsection, has the first obligation to pay benefits is termed the "primary" program, and the coverages it provides are "primary." The other program (and the coverages it provides) is termed "secondary."
- (b) Any other program which provides group or individual automobile, homeowner's, or premises insurance, including medical payments, personal injury protection, or no-fault coverage, is primary to the extent that either the enrollee's out-of-pocket expenses have been first satisfied or the coverage is unlimited.
- (c) When the other program does not contain a COB provision, that program is always primary.
- (d) When the other program contains a COB provision and the order of benefit determination under both programs' COB provisions establish this Program as primary, the provisions of this program determine this Program's liability, regardless of any payment the other program may have made.
- (e) When the other program contains a COB provision, the following order of benefit determination will be used.
 - (i) The program covering the enrollee as an employee will be primary over the program covering the enrollee as a dependent.
 - (ii) When the enrollee is a dependent child whose parents are not divorced or separated, the program covering the enrollee as a dependent of the parent whose birthday occurs earlier in the calendar year will be primary over the program covering the enrollee as a dependent of the parent whose birthday occurs later in the calendar year. If the two parents' birthdays fall on the same day, the program which has covered the parent for the longer period of time will be primary. If the other program does

not have the provisions of this subsection regarding dependents, and as a result both programs would take a primary position or both would take a secondary position, the provisions of this subsection will not apply and the rules of the other program will determine which program is primary.

- (iii) When the enrollee is a dependent child whose parents are divorced or separated, and if there is a court order establishing financial responsibility with respect to health care expenses of the child, the program which covers the child as a dependent of the parent with such responsibility shall be primary. If there is no court order, and the parent having custody of the child has not remarried, the program covering the child as a dependent of the parent with custody shall be primary. If there is no court order and if the parent having custody has remarried, the program covering the child as a dependent of the parent having custody shall be primary, any program covering the child as a dependent of the stepparent shall be secondary, and the program covering the child as a dependent of the parent without custody shall determine its liability last.
- (iv) When rules (i), (ii), and (iii) above do not establish an order of benefit determination, the program which has covered the enrollee for the longer period of time will be primary. However, if one program covers the enrollee as an active employee (or dependent of such employee) and the other covers the enrollee as a laid-off or retired employee (or dependent of such employee), the program covering the enrollee as an active employee (or dependent of such employee) shall be primary. Also, if the other program does not have a provision regarding laid-off or retired employees, and as a result both programs take a secondary position under their respective rules, the provisions of this subsection (iv) shall not apply and the rules of the other program shall determine which program is primary.

6. Payment of Benefits

- (a) If this is primary then the provisions of this Program determine the Program's liability regardless of any provisions of the other program. If this Program is primary, a carrier may reimburse a secondary program for any amounts paid by such program which should have been provided by this Program.

- (b) If benefits under this Program are overpaid by a carrier for any claim involving COB, the carrier shall have the right to recover such overpayment from the hospital, physician, or other provider of service, from the other program, or from the primary enrollee, as appropriate.
- (c) With regard to any claim for which this Program has secondary liability, benefits provided under this Program shall not exceed the amount of benefits payable if this Program had been primary.
- (d) "Benefits paid or payable" under another program include the benefits that would have been payable had a claim been made under the primary program, or which would have been payable by the primary program but for the enrollee's failure to comply with the provisions of such program. When benefits are provided in the form of services rather than cash payments, the reasonable cash value of such services rendered will be deemed to be a benefit payable with the collection of an overpayment for the Program.
- (e) When this Program is secondary,
 - (i) sanctions provided under this Program (e.g., for failure to obtain predetermination, for failure to obtain a required second opinion, for failure to obtain services from a panel provider, etc.) will not apply,
 - (ii) payment will be made only to the level which would have been paid by this Program had it been primary, and
 - (iii) no payment will be made for services which are not covered under this Program.

7. Reimbursement for Third Party Liability – Subrogation

- (a) If health care benefits are paid to, or on behalf of, an enrollee and if the enrollee makes recovery from a third party, individual or organization for any covered expenses for which benefits were paid, the Program shall be entitled to reimbursement in an amount equal to the benefits paid to, or on behalf of, the enrollee under this Program. Carriers administering the Program shall take such actions as may be necessary to preserve or assert such right of reimbursement on the Program's behalf.

- (b) The enrollee shall perform such acts and shall execute and deliver to the Corporation or the carrier such instruments and papers as may be necessary to secure such rights of reimbursement.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Mark J. Gendregske

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Nate Gooden

September 27, 1999

(C-27) Coordination of Benefits Cost Avoidance

International Union, UAW

Attention: Mr. Stephen P. Yokich

Dear Sirs:

During the course of these negotiations, the parties have discussed the serious cost impact of paying health care expenses which properly should be the responsibility of other employers. To the extent Program enrollees have primary coverage through another plan and file claims with that plan first, our Program deals only with secondary balances, and our costs are reduced without impacting overall benefits available to the enrollee. Consequently, the parties are committed to modifying the coordination of benefits process, so that it will focus effectively first on cost-avoidance and second on cost-recovery.

In making this commitment, the Union stated its concern that an enrollee cooperating fully with the Program might, nonetheless, be placed in jeopardy by non-cooperation of providers, carriers or others. Although we believe the vast majority of claims for which the Corporation has primary responsibility, or which represent secondary balances after a primary plan has paid, are processed within twenty (20) business days of receipt by the carriers, as further protection to the enrollee, the following commitments were made:

1. Program claim systems have been adjusted so that in appropriate cases they assume the Program is primary and complete processing;
2. Jointly developed educational efforts will be undertaken to familiarize enrollees, UAW Benefit Plans Representatives and Benefit Administrators with the value of effective coordination of benefits, with the basic rules for determining priority between plans, with the appropriate claim filing practices and how to provide the necessary information to the Corporation and/or carriers;
3. Processes will be implemented by which primary enrollees will routinely and regularly report availability of other coverage applicable to covered dependents;
4. Carriers will be instructed to perform both external coordination with other carriers and internal "plan-on-plan" coordination to the fullest possible extent, thus minimizing delay and any potential employee inconvenience;
5. When it is necessary to obtain claim payment information from another plan that is primary before the claim can be processed by the Program carriers, both providers and enrollees will be advised, providers will be asked to file with any identifiable primary plan first, and providers will be asked to contact the Program carrier before any attempt to collect from the enrollee;
6. The Corporation and the Union will designate specific individuals to be contacted for assistance and intervention in the event an enrollee is placed in jeopardy by the actions of other plan carriers and/or providers; and
7. To protect the enrollee, the above specified individuals will jointly have the authority to instruct the carriers to pay an outstanding properly submitted claim when they deem it appropriate to do so. The carrier then will continue to pursue recovery from the primary plan.

As we have discussed, this cost-avoidance approach to coordination of benefits will align our administrative practice with the routine practices of the majority of major plans. It is understood and followed by both the provider and carrier communities.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Stephen P. Yokich

October 12, 2011

(C-28) COBRA

International Union, UAW

Attention: Mr. General Holiefield

Dear Sirs:

Pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and related DOL and IRS regulations, the Company is required to offer health care coverage continuation to employees and their eligible dependents upon loss of coverage under the Health Care Plan for reasons such as termination of employment. Such coverage is paid by the enrollee and is based on the Company's Health Care Plan rates.

It is agreed that all eligible employees covered by the 1990 National Production and Maintenance and Parts Depot Agreements between the Company and the International Union, UAW shall be eligible for COBRA coverage upon the occurrence of a qualifying event as defined in the law resulting in loss of Health Care Plan coverage.

A summary of the Company's procedures for compliance with COBRA is attached. It is also agreed that the Company will continue to remain in compliance with COBRA and will modify its procedures for any changes in the law or IRS regulations.

Very truly yours,

CHRYSLER GROUP LLC
By Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By General Holiefield

Compliance with provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 "COBRA" or "Act" allowing certain persons to voluntarily continue group health care coverage.

1. The Company will comply with the law which provides that eligible employees and family members ("Qualified Beneficiaries"), upon the occurrence of certain events ("Qualifying Events") which result in the loss of health care coverage, are given the opportunity to continue group health care coverage at their own expense ("COBRA Coverage") for a specified maximum period. It is agreed that if the qualifying event is either (i) termination of employment or (ii) reduction of hours, but the employee is reinstated without a loss of coverage prior to the expiration notification period, then the Company shall not be obligated to send the notification to the employee or other qualified beneficiaries. A determination of whether and when a "loss of coverage" occurs shall be based on coverage for which a qualified beneficiary was eligible and enrolled not waived or cancelled as of the day before the qualifying event.
2. Administration of the COBRA program will be in accordance with the Act (as amended) and with DOL and IRS regulations that are consistent with reasonable interpretation of the Act. The terms of the Company's COBRA program shall not exceed those requirements unless agreed to below or elsewhere in this agreement (i.e. UAW contract).
3. The Company may designate administrative agents to carry out all or part of the COBRA program, such as: employee notification; qualified beneficiary notification; distribution, receipt and processing of COBRA elections; computation and distribution of COBRA premium notices; receipt of premium payments; COBRA eligibility determination; and communication to employees or qualified beneficiaries who have questions about COBRA.
4. Employees who are subject to this agreement, as well as their spouses and eligible dependents, may be eligible for COBRA coverage as a result of qualifying events that occur.
5. A COBRA contract shall be treated the same as a health care contract established for an active employee pursuant to this

agreement with regard to coverage, benefits, plan design, and carrier choices or assignment.

All COBRA enrollees must continue to meet all of the eligibility provisions as set forth in this agreement. If a qualified beneficiary ceases to be eligible to remain as a member on another qualified beneficiary's COBRA contract due to a second qualifying event, they shall be offered COBRA coverage under a separate COBRA contract for the duration of the applicable maximum COBRA eligibility period. Except for children born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, individuals who are added to a contract subsequent to the initial qualifying event, do not have the right to make independent election of coverage.

6. A qualified beneficiary may elect only those coverages for which they were eligible on the day before the qualifying event and were neither waived nor cancelled. If a qualified beneficiary who, on the day before the qualifying event, did not have all lines of coverage elects COBRA coverage, the COBRA premium will be adjusted to reflect only those which are in effect.

Unless separate elections are received during the COBRA election period, the election of an employee who has experienced a qualifying event is binding upon covered dependents and the election of an ex-spouse who has experienced a qualifying event is binding upon the ex-spouse's dependents as well.

7. When a COBRA contract is established, coverage shall be maintained with the same carrier(s) which was (were) in effect for the qualified beneficiary on the day before the qualifying event. If, however, because of plan provisions the carrier(s) are not available to the COBRA contract holder, a selection may be made from the other carriers available at that time. COBRA contract holders shall be allowed to make carrier changes during open enrollment periods.
8. If the Company, pursuant to this agreement, makes available to qualified beneficiaries alternative health care coverage continuation privileges that do not satisfy all of the requirements of COBRA continuation coverage, they shall have the option to elect either COBRA continuation coverage or that alternative continuation coverage. An election of COBRA coverage will terminate the enrollee's eligibility for alternative coverage.

If a primary enrollee is entitled to choose between COBRA continuation coverage and alternative continuation coverage, the alternative continuation coverage for the enrollee and their eligible dependents shall be continued unless the enrollee chooses COBRA. If the primary enrollee or eligible dependent makes a timely election of COBRA coverage and makes timely payment of the COBRA premium, coverages will be adjusted retroactively to provide the desired coverage from the date of the qualifying event.

If the primary enrollee elects COBRA coverage in lieu of alternative continuation coverage, none of the eligible dependents may maintain alternative continuation coverage.

Unless the primary enrollee and/or one or more of the eligible dependents make a timely election of COBRA coverage and timely payment of the required COBRA premium, it shall be presumed that all qualified beneficiaries have elected alternative continuation coverage.

If the Company makes available to a qualified beneficiary alternative continuation coverage that satisfies all of the requirements for COBRA continuation coverage, the qualified beneficiary will be allowed to integrate the two coverages.

9. In the absence of regulations describing how COBRA premiums may be computed, the Company COBRA rates shall be set at 102% (150% for the eleven (11) months of additional coverage provided to disabled qualified beneficiaries) of the applicable national cash pay rate based on contract size (self, two-party, or family), lines of coverage included, and type of plan (Standard Care Network, PPO or HMO). The rates shall not vary by specific carrier. The Company may revise the formula as permitted or required by regulation. The Company rate may be adjusted as frequently as allowed by law. Interim adjustments may be made in accordance with changes in contract size (self, two-party or family).

As stipulated by law, the premium for the “pre-election” period of coverage and the initial post-election month of coverage must be paid within 45 days of the election date. The election date shall be the date on which the election is received by the designated agent. The pre-election premium must be paid in order to activate the contract. Regular monthly premiums for COBRA coverage are due on the first day of the month of coverage with a 30 day grace period. Claims will not be honored until the premium payment covering the date of

service has been received by the designated agent. Failure to pay premium in full by the deadline, except in cases of insignificant underpayment as defined by IRS regulations, shall result in cancellation of the COBRA contract as of the last date covered by the previous full and timely payment.

10. Once a COBRA contract or alternative continuation coverage has been cancelled, none of the persons covered by that contract may reactivate coverage except during the COBRA election period. Once an individual qualified beneficiary ceases to be eligible for COBRA coverage, his COBRA coverage may not be reinstated. Coverage may not lapse for any period between the qualifying event and the start of continuation coverage.

November 20, 2023

(C-29) National Managed Pharmacy Program (NMPP)

International Union, UAW

Attention: Mr. Rich Boyer

Dear Mr. Boyer:

During these negotiations, the parties concluded that the present delivery of prescription drug benefits could be improved. Therefore, the Company and the Union agreed to jointly develop and implement a National Managed Pharmacy Program (NMPP) that would be consistent with the Program goals of quality care and cost effectiveness. The NMPP will have at least generally similar quality and at least the same covered benefits and accessibility standards as the Preferred Prescription Plan presently available to hourly and salary enrollees in Michigan.

The parties agreed to the components listed below which, when integrated and fully implemented, will comprise a NMPP. The parties further agree to review and evaluate each component and provision listed below. Implementation of any or all components or provision in the NMPP will be on the basis of mutual agreement.

A. Program Structure

1. A nationwide, limited network of participating pharmacies including local and national pharmacy chains, as mutually agreed to for prescription drugs will be developed to provide

ready-access for hourly and salary employees, retirees, and eligible surviving spouses and their eligible dependents. The NMPP also will have the flexibility to expand or reduce the network as appropriate, based upon access standards, by mutual agreement between the Company and the Union. The parties agree to review the full complement of retail networks available to the NMPP through the Program Administrator on an ongoing basis for purposes maintaining access and quality while reducing costs.

2. The NMPP will contain Drug Utilization Review (DUR) requirements to review whether patients receive appropriate drug therapy as measured against generally accepted pharmaceutical practices. Such Program will incorporate concurrent and retrospective DUR, along with a voluntary drug formulary and mandatory program to promote the use of generic prescription drugs, where appropriate (Maximum Allowable Cost Program). In addition, DUR will identify a variety of critical drug therapy problems including but not limited to:
 - a. drug-disease conflicts;
 - b. drug-drug interactions;
 - c. allergy alerts;
 - d. therapeutic duplicates;
 - e. early refills;
 - f. age/gender prescription conflicts;
 - g. over-utilization; and
 - h. under-utilization.
 - i. drug/pregnancy

The above list of critical drug therapy problems may be modified by mutual agreement between the parties.

3. Quality assurance mechanisms will be designed to identify routinely inappropriate drug prescribing that could result in adverse medical outcomes, including hospitalization, by incorporating the following components:
 - a. a total quality management (TQM) philosophy;

- b. rigorous pharmacy program management and performance monitoring;
 - c. prescribing physician reeducation as necessary;
 - d. client-specific program performance management;
 - e. patient medication compliance monitoring; and
 - f. outcomes assessment analyses.
4. The NMPP will provide for a comprehensive on-line, point-of-service claims processing system with an electronic telecommunications network that will help facilitate management of enrollee eligibility verification, formulary information, drug prescribing protocols, drug utilization review, pharmacy reimbursement, and possibly expanded patient information to make informed dispensing decisions.
 5. Physician profiling will be incorporated into the NMPP to target physicians who exhibit persistently inappropriate prescribing patterns across their practices when compared to their peers.
 6. Pharmacist profiling will be incorporated also.

As a result of concerns identified above, the NMPP will provide for intensive individual physician and pharmacist education as necessary.

B. Program Benefits

1. The following prescription drug coverages will be provided for hourly and salary employees, retirees, eligible surviving spouses and their eligible dependents enrolled in Standard Plan coverage:
 - a. prescription drug expense benefits will be those standard and mail order benefits described in Article III. of the Program;
 - b. for prescription drug services received from a participating provider under the NMPP, a Program member will have no out-of-pocket expenses except for the applicable copayment as described in Article III, Section 3. A. and the expenses described under the Maximum Allowable Cost Program provided under the National Account Program, for each prescription order or refill of a covered drug;

- c. a Program member who receives prescription drug services from a non-participating provider in an emergency (defined as the need for medication to alleviate pain and suffering or to prevent the progression of an acute course of illness) will be entitled to full reimbursement less a copayment as described in 1. b. above for each prescription order or refill of a covered drug.
- d. Parties may add or delete drugs from the Maintenance Drug List, as necessary, on a mutually agreeable basis.

C. Program Administrator

1. The Program Administrator will be selected jointly by the Company and Union.
2. The Program Administrator will establish uniform pharmacy protocols, pharmacy auditing procedures, drug utilization review processes and quality assurance procedures. From time to time, the Program Administrator may make recommendations to the Company and Union with regard to implementing specific components (including but not limited to prior authorization for dangerous or abused drugs, step care therapy, appropriate quantity, dose optimization, safety edits, and a review of selected therapeutic classes for appropriate use) of the Program. These recommendations will be reviewed by the parties and implemented by mutual agreement.
3. The Administrator will provide the Company and the Union with data reports that shall include, but not be limited to, such information as utilization of services, costs, quality measurements, use of various categories of drugs (e.g., generic, single source, multi-source, etc.), provider prescribing patterns and patient outcomes.
4. The Administrator will monitor retail pharmacy network performance and will report such aggregate data, along with recommendations for retail network enhancements, regularly to the Company and the Union.
5. The Administrator will establish a network of participating retail network providers to provide satisfactory service to the enrollees and obtain contracts that have been reviewed by the Company and the Union, with such providers. The Administrator will ensure that network pharmacists are selected, in part, on quality assurance criteria. In contracting

with the participating providers, the Administrator will ensure that the providers fully understand the provisions of the NMPP, including eligibility requirements and benefit levels. The Administrator will negotiate appropriate fees with such participating providers.

6. The Administrator will contract with a mail order pharmacy network that has been reviewed and approved by the Company and the Union. In contracting with the mail order pharmacy network, the Administrator will ensure the mail order pharmacy network fully understands the provisions of the NMPP including eligibility requirements and benefit levels. The Administrator will negotiate appropriate fees with the mail order pharmacy. The copayment for a prescription received from the mail order pharmacy shall be as described in the provisions regarding mail order coverage in Article III. of the Program.
7. The Administrator will make benefit payments to the participating providers or, in the case of services received from non-participating providers, the Administrator will make benefit payments to the member or non-participating provider, as appropriate.
8. The Administrator will prepare appropriate communications regarding the NMPP for enrollees, network pharmacists and, as necessary, for prescribing physicians.
9. The administrator will make equally available to the Company and Union, on a regular basis, data relevant to evaluating the performance of the NMPP from the standpoint of access, quality, and cost effectiveness.
10. The Administrator will undertake these responsibilities through a contract with the Company that provides for performance standards with appropriate guarantees.

Very truly yours,

FCA US LLC
By Christopher Fields

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Rich Boyer

December 16, 2019

(C-30) New Procedures Process

International Union, UAW

Attention: Mrs. Cynthia Estrada

Dear Mrs. Estrada:

During these negotiations, the Company and the Union agreed to utilize the established procedure for implementing the addition of new or revised services or items to this Program in accordance with the Three Auto Company/UAW agreement. Notwithstanding such Three Auto Company/UAW agreement, however, new procedures proposed by the Control Plan that have a first year cost of no more than \$0.015 per contract per month (PCPM), will be automatically implemented when they are covered by the provisions of the benefit plan.

A proposal for the inclusion in the Program of a new or revised service or item may be submitted to the Control Plan by a carrier, physician or physician group, a professional organization, a provider or provider group, the Company or a union representing employees to whom the Program applies. The Control Plan shall review such proposal and make written recommendation(s) to the Company regarding whether or not the service or item should be added to the Program. Such recommendation shall take into account, but not be limited to, the following considerations:

1. whether the procedure is routine (projected cost impact of \$0.015 PCPM or less) or non-routine as determined by the Control Plan,
2. quality of care, access or utilization concerns and the proposed steps to resolve such concerns,
3. replaced or discontinued procedure(s) and a plan for discontinuation of coverage for such procedures,
4. provider class(es) for which the procedures are being recommended,
5. Plan options (i.e. Traditional, PPO or both) for which the procedure(s) is recommended,
6. positive or negative impact on Program costs,

7. information on national and local Medicare policy and payment practices and,
8. anticipated issues in implementing the new procedure on a national basis.

Recommendations for the addition of a routine new procedure, or a change to an existing procedure, will be distributed to the Three Auto Companies, who will have thirty (30) business days to review the proposal. If the Company is not in agreement with the recommendation, or has questions, notification to the Control Plan is required within ten (10) business days of receipt of the proposal. When the Control Plan receives notification, the Control Plan shall schedule a meeting within the first twenty (20) business days of receipt of the proposal. Absent notification to the Control Plan by the Company, the new procedure will be considered accepted.

Blue Cross and Blue Shield of Michigan, or another carrier shall be required to monitor the utilization of such new procedures and report to the Joint Insurance Committee after sufficient experience has occurred but in no event later than twelve months following implementation, the actual costs of each new procedure.

Very truly yours,

FCA US LLC
By Glenn Shagena

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Cynthia Estrada

September 27, 1999

(C-31) ASF/FASC

International Union, UAW

Attn: Mr. Stephen P. Yokich

Dear Sirs:

During these negotiations, the parties discussed the criteria that would be applicable for determining coverage for services

provided by Ambulatory Surgical Facilities (ASF) and Freestanding Ambulatory Surgical Centers (FASC).

The parties agreed that, subject to approval for benefit payment by the carrier, the criteria that is applicable for a ASF/ FASC to be recognized as an approved facility under the Program is shown below:

- must meet all local state licensing and any Certificate of Need (CON) requirements that may exist in the state; and
- be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association or the Accreditation Association for Ambulatory Health Care (AAAHC), and
- be approved for reimbursement as an ambulatory surgical center (ASC) under Medicare; and
- have a written referral agreement with at least one acute care hospital; and
- if required by the carrier, meet any carrier-designated need tests and enter into a written agreement with the local carrier to provide services in accordance with established reimbursement and utilization review policies for such facilities; and
- must provide ambulatory surgery in at least five of the following surgical procedure categories: integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/ocular, adnexa and auditory; provided, however, if fewer services are allowed, they must be subject to a Certificate of Need (CON) being granted by the state or permitted by other carrier-designated need tests.

To the extent a local carrier has a process for relating approved capacity to anticipated need and actual capacity within the area exceeds anticipated need, the carrier may, with the approval of the parties, contract with a limited number of facilities. Similarly, the Corporation and the Union may conclude that it is in the best interest of the Program to limit approved outpatient surgical capacity in a geographic area. In such cases, selections will be made on the basis of quality and cost. Further, the Corporation and the Union may withdraw approval of particular facilities in the event of quality concerns.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Stephen P. Yokich

October 22, 2015

(C-32) Criteria for Reviewing HMOs

International Union, UAW

Attention: Mr. Norwood H. Jewell

Dear Sir:

During these negotiations, the Company and the Union discussed Criteria to be considered when reviewing Health Maintenance Organizations (HMOs).

The Company agrees that new HMOs selected for joint approval for offer to Chrysler employees represented by the Union during future open enrollments must provide benefits equivalent to the specifications described on the attachment. In addition, the parties recognize that under the prior provisions, some HMOs may not have provided benefits meeting these Criteria. As soon as practical after the effective date of this Agreement, the Company will ask those HMOs not meeting these Criteria to make required benefit changes to meet the standards set forth in the Letter indicated above. These benefit changes will be effective beginning no later than January 1, 2016. Following is a list of HMOs newly subject to this letter that may be deficient in one or more aspects listed below. Jointly approved HMOs not identified on the attached list will be surveyed to ensure compliance.

Revised HMO Criteria
HMOs Expected to Improve to Chrysler Group LLC Level

Plan Name	Location
Health Alliance Plan	Michigan
Blue Care Network	Michigan
HealthSpan	Ohio

Kaiser Permanente
Kaiser Permanente

California-North & South
Colorado

These benefits shall be modified upon agreement by the parties as detailed below in the Schedule of Benefits For Evaluating HMOs and are effective January 1, 2016.

Very truly yours,

FCA US LLC
By Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Norwood H. Jewell

Attachment

**SCHEDULE OF BENEFITS FOR EVALUATING HMO's
TO BE OFFERED TO CHRYSLER
EMPLOYEES REPRESENTED BY THE UAW**

BENEFIT	HMO
INPATIENT-HOSPITAL	All services must be provided, ordered, prescribed, or recommended by the HMO or insurance carrier physician except in the case of emergencies where the HMO rules of reporting shall apply.
Room and Board	Semi-Private room covered in full. Private room covered, if medically indicated.
Benefit Period	Unlimited.
Maternity Admission	Unlimited.
Surgery (includes plastic, cosmetic, and reconstructive surgery for congenital anomalies, correction of conditions resulting from accidental injuries or traumatic scars, and correction of deformities resulting from cancer surgery, such as following medically necessary mastectomies).	No Charge - covered in full.

Hospital Physician Service	No charge - covered in full.
Surgical Assistance	No charge - covered in full, when medically necessary.
Ancillary Services	No charge - covered in full.
Physical Therapy	No charge - covered in full.
Consultations	No charge - covered in full.
Pulmonary Tuberculosis	No charge - covered in full.
Affiliated Hospitals	No charge - covered in full.
Non-Participating Hospitals	No charge if admitted by a plan doctor, or for an emergency.

OUT-PATIENT SERVICES

Out-patient Surgery	No charge - covered in full.
Hospital Services	No charge - covered in full.
Diagnostic Laboratory and X-ray	No charge- covered in full.
Routine Office Visits	\$25 copay per visit.
Doctor's Home Visit	No charge - covered in full when medically indicated.
Physician Exams	\$25 office visit copay.
Pediatric Exams	\$25 office visit copay.
Allergy Testing and Injections	\$25 office visit copay.
Other Injections and immunizations	\$25 office visit copay.
Smears (annually)	No charge - covered in full.
Physical Therapy	No charge - up to 60 visits per condition.
Urgent Care	\$50 copay

EXTENDED CARE FACILITY

Benefit Period	No charge - covered in full. Unlimited number of days. Custodial care not covered.
Physician Services	No charge. Unlimited number of visits.
Consultation	No charge - covered in full.

EMERGENCY

In-Area	\$100 copay, waived if admitted. Authorization must be obtained as soon as possible either before or after treatment.
Out-of-Area	\$100 copay, waived if admitted. Authorization must be obtained as soon as possible either before or after the occurrence. This is world-wide coverage.
Ambulance	No charge - covered in full when medically necessary, to or from hospital, or both ways.

MENTAL HEALTH CARE

Hospital Inpatient	No charge for 1st 45 days, per disability. This benefit renews when member has been out of the hospital for 60 days.
Extended Care Facility	No charge - covered in full. 90 days per disability. This benefit renews when member has been out of the hospital for 60 days. Custodial care not covered.
Partial Hospitalization/ Psychiatric Admission	No charge for 90 days, per disability. (Two days for each unused day of psychiatric hospitalization.) This benefit renews when member has been out of the hospital for 60 days.

Out-Patient Psychiatric First twenty (20) visits covered at no charge, per contract year or calendar year.

Psychological Testing No charge - covered in full.

Electroshock Therapy No charge - covered in full.

ALCOHOLISM AND DRUG ADDICTION CARE

In-hospital No charge - covered in full. Up to 45 days as medically indicated. The benefit renews when member has been out of hospital for 60 days.

Out-Patient Therapy No charge - covered in full. Up to 35 visits/calendar year or contract year.

OTHER SERVICES

Prescription Drugs HMO's shall have the prescription drug copays outlined in Article III, Section 3.A.(1).(b)
Insulin needles and syringes are covered.

Chemotherapy No charge - covered in full. Inpatient and Outpatient.

Blood No charge - covered in full for administration and plasma, whole blood covered if replaced.

Coordinated Home Care No charge - covered in full when medically indicated.

Hemodialysis No charge - covered in full; Inpatient and Outpatient.

Radiation Therapy No charge - covered in full.

Prosthetic and Orthotic Appliances No charge - covered in full.

Durable Medical Equipment No charge - covered in full.

Private Duty Nursing	No charge - covered in full when medically necessary.
Family Planning and Infertility Services	No charge - covered in full.
Sterilizations	No charge - covered in full.

HEARING AID BENEFITS

Examinations	No charge - covered in full.
Hearing Aid	No charge - covered in full when medically indicated.
Limitation	As medically indicated. (Repair of broken aids or replacement of lost aids may be restricted to not sooner than 36 months from day of acquisition of a hearing aid.)

MISCELLANEOUS

When Medicare is primary	Complementary Benefits.
Maternity Benefits	Immediate.
New Born Dependent Coverage	Date of Birth.
Eligible Dependent Coverage	Age 19-26.
Sponsored Dependents	Covered at Employee's Expense.
Patient Grievance Procedure	Provided.
Conversion Privilege	Provided.
Enrollment Outside HMO Service Area	Not covered.

October 14, 1996

(C-33) HMO Vision Coverage

International Union, UAW

Attention: Mr. Jack Laskowski

Dear Sirs:

During these negotiations, the Corporation and the Union agreed to review the cost of the vision care benefit provided under the Health Maintenance Organization (HMO) plan option.

The parties agreed that, where it is determined more cost effective to do so, the vision benefit for employees, retirees, surviving spouses and their eligible dependents enrolled in an HMO shall be transferred from the HMO and provided through the local Blue Cross Blue Shield Plan or an alternative vision care plan where available.

Very truly yours,

CHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Leonard J. Paula

Letter Originated - November 19, 1990
John D. Wilson (Corporation)
Leonard J. Paula (Union)

October 22, 2015

(C-34) Out-of-Area Vision Coverage

International Union, UAW

Attention Mr. Norwood H. Jewell

Dear Sir:

During these negotiations, it was agreed that the out-of-area reimbursement under the Vision Program applicable to members

who do not have an affiliated provider within 25 miles of their home address may receive reimbursement for services from a non-affiliated provider, provided they are otherwise eligible, in accordance with the following schedule effective January 1, 1997:

Eye Examination	\$39
Frame	\$38
Single Vision Lenses	\$38
Bifocal Lenses	\$38
Trifocal Lenses	\$55
Contact Lenses	(including exam, professional fee and lenses):
Medically Necessary	\$148
Cosmetic	\$55

In addition to the above changes, the Company will instruct the Vision Carrier to continue the same general level of frame quality and selection as administered under the previous agreement.

Very truly yours,

FCA US LLC
By Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Norwood H. Jewell

September 27, 1999

(C-35) Home Health Care

International Union, UAW

Attn: Mr. Stephen P. Yokich

Dear Sirs:

During these negotiations, the Corporation and the Union discussed certain issues associated with administration and payment of Home Health Care benefits. To resolve these issues, the parties agreed to the following changes to the Home Health Care program.

Effective July 1, 2000, infusion therapy services will be a covered benefit under the Home Health Care Program. Accordingly, the following provisions will apply to such services:

1. The "homebound" requirement will be waived with respect to home infusion therapy patients.
2. Related nursing services will be included.
3. Applicable prescription drug benefits will be included.
4. Coordinate with the DME benefit administrator which includes hyperalimentation and home chemotherapy services.
5. Waive the provision that limits home health care benefits to three visits for each remaining inpatient hospital day.
6. Require that covered home infusion therapy services be available only when delivered by a provider that is accredited by the Joint Commission on Accreditation of Healthcare Organizations. If applicable, waiver of this requirement will be based only on mutual agreement between the parties.

The parties further agreed that the Joint Insurance Committee will evaluate any new advanced technology or patient management protocols to determine the appropriateness for inclusion in the Program. In addition, the parties will consider a general restructuring of the program.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Ronald D. Gurdak

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Stephen P. Yokich

October 12, 2011

(C-39) Hyperbaric Oxygenation of Wounds

International Union, UAW

Attention: Mr. General Holiefield

Dear Sirs:

Hyperbaric oxygenation is covered in the outpatient hospital setting, subject to current Program Standards, when medically necessary for treatment of disease or injury. Further, new or revised conditions for this treatment will be considered in accordance with Letter (C-30) New Procedures Process.

Very truly yours,

Chrysler Group LLC
By: Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By: General Holiefield

October 22, 2015

(C-41) Same-Sex Domestic Partner Benefits

International Union, UAW

Attention: Mr. Norwood H. Jewell

Dear Sir:

During the recently concluded negotiations, FCA US LLC and the UAW agreed to study the potential offering of same-sex domestic partner health care benefits. We have reviewed the practices of several major companies who offer such benefits.

The parties have agreed to offer domestic partner benefits in recognition that the Company employs, and the UAW represents, people from various and diverse backgrounds. The Company and the UAW value diversity and strive to ensure that their policies and practices are inclusive and non-discriminatory.

Therefore, consistent with our belief that a diverse workforce is an important asset, and in line with the interest to be fair, equitable and fiscally responsible, the Company and the UAW have agreed to expand the eligibility requirements to eligible same-sex domestic partners of eligible active employees for hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverages effective August 1, 2000.

Eligibility Rules for Same Sex Domestic Partners

Effective August 1, 2000, the Company will offer domestic partner hospital, surgical, medical, prescription drug, dental, vision, and hearing aid coverages to eligible active employees who have a qualifying same-sex domestic partner relationship.

This understanding is an expansion of Article III, Section 2.B and C. of the H-S-M-D-D-V Program, presently available under our Agreement for active employees and their eligible dependents. In addition, all other provisions of the H-S-M-D-D-V Program shall apply.

In the event an active employee dies while having an eligible domestic partner enrolled for coverage, the Company will continue hospital, surgical, medical, prescription drug, hearing aid coverages (but not dental or vision expense coverages) for the enrolled and eligible domestic partner (and eligible children, if any) as if the domestic partner were a surviving spouse under Article III, Section 1.B.(1). of the H-S-M-D-D-V Program, provided such domestic partner otherwise meets the terms of Article III, Section 1.B.(1). (a domestic partner for this purpose will be treated as a surviving spouse if the domestic partner relationship has existed for at least one year immediately prior to his/her death). Nothing contained herein shall be construed as providing eligibility for monthly survivor income benefits.

The parties agree that a same sex domestic partner is defined as a relationship between two people who meet ALL of the following criteria:

- Are the same sex;
- Have shared a continuous committed relationship with each other for no less than six (6) months, intend to do so indefinitely, and neither has any such relationship with any other person;
- Are jointly responsible for each other's welfare and financial obligations;

- Reside in the same household;
- Are not related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of their state of residence;
- Must reside in a state where marriage between persons of the same sex is not recognized as a valid marriage by the state, or, if residing in a state which recognizes same-sex unions, enter into such union as is recognized by the state;
- Each is over age 18, of legal age, legally competent to enter a contract; and
- Neither is married to a third party.

Employees will be required to submit a notarized affidavit attesting that their domestic partner relationship meets all of the above criteria. The effective date of coverage will be the date the affidavit is notarized, provided the employee is otherwise eligible for health care coverage and notifies the Company within 30 days from the date the affidavit is notarized, or, if later, the first of the month following receipt of the affidavit by the Company.

The Company shall have the right of determining eligibility for the benefit, consistent with the provisions described above. The primary enrollee claiming initial or continuing eligibility of a domestic partner and/or dependent(s), if any, shall furnish any documentation that may be necessary to substantiate the claimed eligibility of the domestic partner and/or dependent(s).

The parties agree that in those instances where a legal jurisdiction (i.e., state) recognizes same sex marriages, or other forms of same-sex unions, a legal marriage, or other legal union, will be required to establish or continue coverage for those employees who reside in such jurisdiction.

In these cases, coverage will be effective as of the date of the marriage, or other such state recognized union, provided the employee is otherwise eligible for health care coverage and notifies the Company within the time limitations currently in place for adding a dependent.

Children of an employee's domestic partner will be considered eligible if they meet the requirements to be the employee's dependents under Section 151 and 152 of the IRS code. In those cases, employees will not be taxed on the value of the child's coverage (see Tax Consequences below).

It continues to be the employee's responsibility to remove dependents who are no longer eligible for coverage under the Company-provided health care plans, i.e., at the point in time when they are no longer eligible under the provisions of our negotiated agreements and this letter of understanding.

Continuation of Coverage

Same-sex domestic partners, when deleted from Company-provided coverage, do not qualify for COBRA coverage under the federal government's regulations regarding COBRA continuation of coverage. In addition, certain alternative plans may not provide COBRA-like coverage. The Company is in the process of making arrangements for a COBRA-like cash pay continuation of coverage with eligibility rules and payment arrangements as apply under COBRA for persons who no longer meet the eligibility rules as defined in this letter and under our bargaining agreement.

Tax Consequences

Because of IRS regulations, enrollment of a domestic partner is likely to result in tax consequences since the IRS and state laws do not presently recognize a same-sex partner as a legal spouse. The parties agree that in those instances when the non-employee partner does not qualify as a dependent of the employee under Sections 151 and 152 of the IRS code, the fair market value of the benefits provided for the partner will be imputed (taxable) income to the employee.

The Company will assume that when an employee enrolls a same-sex domestic partner for hospital, surgical, medical, prescription drug, dental, vision and hearing aid coverages, the domestic partner does not meet the IRS code requirements for dependent status, unless the employee provides acceptable proof to the Company to the contrary.

Confidentiality

As with all personnel files, health care elections are treated as strictly confidential information. Company and UAW Benefits Representatives will be instructed regarding the confidentiality of all benefit matters and to apply strict confidentiality regarding the issue of domestic partner eligibility.

Health Care Plan Options Accepting Same-Sex Domestic Partners

It is the intent of the Company to make same sex domestic partner eligibility available under all health care options offered by the Company to eligible members. Some Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Dental Health Maintenance Organizations (DHMOs) may not make such coverage available to the Company and, therefore, the Company will not be able to make such coverages available to employees who are enrolled under these options.

For example, some state laws may not allow insured plans to provide same-sex domestic partner benefits for health care. In these instances, employees eligible for Standard Care Network coverage who elect domestic partner coverage may change their health care plan to the Standard Care Network (which is self-insured and therefore not subject to such state laws) or to another available alternative plan that does accept domestic partner coverage, concurrent with the effective date of adding a qualifying domestic partner for coverage. Employees not otherwise eligible for Standard Care Network coverage must elect an HMO, if an HMO option is available that provides domestic partner coverage; or may elect the Standard Care Network coverage if no available HMO offers domestic partner coverage concurrent with the effective date of adding a qualifying domestic partner for coverage.

Discontinuation of Same-Sex Domestic Partner Status

Pursuant to the Supreme Court decision in *Obergefell v. Hodges* legalizing same-sex marriage throughout the United States, the parties agreed to remove all benefit provisions providing eligibility for same-sex domestic partners and their children pursuant to the below stated timeline:

Employees who, on January 1, 2016, have benefit coverage provided under the Agreement for a same-sex domestic partner and their children will continue to retain that coverage until December 31, 2016. In order to continue such coverage of any benefit under Exhibit B of the Agreement, the employee must, no later than December 31, 2016 provide documentation to the Company, as required by law to demonstrate proof of marriage.

Should the *Obergefell* decision be overruled or revised, by the Court or Act of Congress, the parties agreed that the eligibility language covering same-sex domestic partners and their children will revert back to the same-sex domestic partner language

contained within this Agreement and the discontinuation of same-sex domestic partner status will no longer have effect.

Very truly yours,

FCA US LLC
By: Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By: Norwood H. Jewell

September 29, 2003

(C-45) Approval for New Pharmaceuticals

International Union, UAW

Attention: Mr. Nate Gooden

Dear Sirs:

During these negotiations, the Parties discussed the safety, efficacy and cost-effectiveness of prescription drugs covered under the National Managed Pharmacy Program (NMPP). The Parties agreed that many drugs may not offer any innovation or advantages in therapy, but are higher in price, potentially jeopardizing the Program goals of patient safety, quality of care and cost-effectiveness. In order to promote safety, efficacy and cost-effectiveness, the Corporation and the Union mutually agreed to establish a joint pharmacy committee, which will be a sub-committee of the JIC.

The JIC will appoint a joint pharmacy committee as soon as practicable following the conclusion of these negotiations, but no later than November 1, 2003. The committee will meet no less than monthly and will evaluate prescription drugs in the Program, with special emphasis on newly approved FDA drugs.

The Parties further agree that this committee may jointly select an independent expert to provide technical guidance as to the clinical and financial impact of these pharmaceuticals on the Program performance and population health. The expert will develop recommendations for inclusion, inclusion with limitations/

restrictions or exclusion from the Program. The carrier will implement the decisions of the Parties with respect to the recommendations.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Mark J. Gendregske

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Nate Gooden

November 20, 2023

(C-46) Health Care Administrative Manual

International Union, UAW

Attention: Mr. Rich Boyer

Dear Mr. Boyer:

During these negotiations, in a concerted effort to improve the administration of health care benefits, the parties agreed to the following time table regarding approval and distribution of the UAW Administrative Manual:

- The current draft of the Health Care Administrative Manual will be updated by the Control Plan with the changes as the result of these negotiations and a copy will be provided to the UAW and the Company no later than December 31, 2024.
- UAW and Company representatives will have 180 days from receipt of the draft to review the updated Administrative Manual and advise the Control Plan of any proposed revisions. Failure to respond within 180 days by either of the parties will result in automatic approval.
- Copies of the approved Administrative Manual will be distributed to the UAW and the Company within 30 days following approval.
- Future benefit changes will be incorporated into the Administrative Manual by the Control Plan within 90 days of such changes.

Very truly yours,

FCA US LLC
By Christopher Fields

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Rich Boyer

September 29, 2003

(C-48) Medical Emergency HIPAA Compliance

International Union, UAW

Attention: Mr. Nate Gooden

Dear Sirs:

During these negotiations, the parties have agreed to modify professional and facility claims processing relating to medical emergency conditions to ensure compliance with HIPAA requirements. It is intended that these modifications will preserve the current medical emergency benefit requirement of "signs and symptoms" and facilitate compliance with HIPAA.

Very truly yours,

DAIMLERCHRYSLER CORPORATION
By Mark J. Gendregske

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Nate Gooden

October 12, 2011

(C-49) Standard Care Network

International Union, UAW

Attention: Mr. General Holiefield

Dear Sirs:

During these negotiations, the current design of the Standard Plan Option was discussed. The parties mutually agreed to update the Standard Plan Option, hereinafter referred to as the Standard Care Network (SCN). The parties will meet immediately following these negotiations to plan implementation. Implementation of the SCN is expected to occur as soon as practicable following the conclusion of these negotiations, but no later than July 1, 2004.

The SCN carriers will be responsible for:

1. providing health care coverage as described in Exhibit B, Article III, Section 3A,
2. predetermination of services, utilization and other reviews as mutually agreed to by the parties to ensure quality and cost effective health care,
3. determining the composition of the network and ensuring that geographic access standards are met,
4. ensuring financial accountability on the part of the networks by withholding a percentage of the reimbursement, capitation, or other mechanisms.

Standard Care Network Option Plan Design:

1. Payment for covered services provided by a network provider will be paid by the Company
2. Payment for covered services provided by a non-network provider will be 90% of the non-network provider's reasonable and customary charges for the same service or, if less, the actual charges.
 - a. The 90% limitation on payment for charges payable to non-network providers shall not apply to (i) an individual who has incurred expenses of \$250 for such covered services in a calendar year or (ii) any covered members

of the individual's family after the individual and such members have incurred a total of \$500 in expense for such covered services in the same calendar year.

3. Office visits by enrollees to network providers, or to other providers with an approved advance referral, are subject to a \$25.00 co-payment per visit. Office visits to non-network providers, without an approved advance referral, are not covered and are the enrollee's responsibility.
4. Urgent care center (UCC) visits are subject to a \$50.00 co-payment for each visit to a network UCC for covered services. For covered services obtained at a non-network UCC, the enrollee is responsible for the network UCC co-payment plus possible additional amounts in excess of the network allowed amount. The carrier's payment to a non-network UCC will be the network allowed amount for the same service, or if less the actual charges, minus the network UCC co-payment. The UCC co-payment will be waived if the enrollee is transferred directly from the UCC to an Emergency Room (ER). In this situation, the provisions for ER co-payment will then apply.
5. ER visits are subject to a \$100.00 co-payment for each visit to an ER. The ER co-payment will be waived if the enrollee is admitted into the hospital directly from the ER to receive covered inpatient hospital services. If the enrollee receives covered ER services at a non-network provider and does not have the ability or control to select a network provider, the carrier will defend the enrollee on the basis that the allowed amount is the reasonable and customary reimbursement for the services or supplies in question. In such situations the enrollee is still responsible for the ER co-payment. The provisions for payment for covered services provided by a non-network provider as stated above are not applicable to ER coverage.
6. Amounts paid by enrollees related to office visits, UCC visits, or ER visits will not be applied to the deductible or out-of-pocket maximums.
7. Network providers shall not balance bill for covered services.
8. The following services shall not be covered when provided by a non-network provider:
 - a. Office visits

- b. Well baby care as defined in Article III, Section 4D2B, XXV
 - c. Immunizations and vaccinations as defined in Article III, Section 4D2B,XXI
 - d. Screenings as defined in Article III, Section 4D2B, XVIII, XIX, XX, XXI, XXIII
 - e. Preventive services as defined in Article III, Section 4D2B XVII, XXIV, XXXIII
9. Mental health and substance abuse will continue to be administered in accordance with the terms and conditions outlined in Article 3, Section 5.

Very truly yours,

CHRYSLER GROUP LLC
By Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By General Holiefield

October 12, 2011

(C-50) Diabetes Self-Management Education and Training

International Union, UAW

Attention: Mr. General Holiefield

Dear Sirs:

During these negotiations, the Company and the Union discussed Diabetes Self-Management Education and Training.

The parties agreed that Diabetes is a serious and costly disease. Diabetes is currently among the most prevalent chronic conditions experienced by our employees and their dependents. It is also known that disease progression is controllable in many cases. Therefore, in an effort to assist members in avoiding the serious complications of Diabetes and in order to facilitate better management of their condition, effective January 1, 2012, in-

network coverage for Diabetes Self-Management Education and Training will be provided for members enrolled in a Company sponsored health plan. Such service must be prescribed by a physician, nurse practitioner or physician assistant.

In accordance with Medicare criteria and standards, coverage will be provided for any member identified as follows:

- New-onset Type I, Type II, Pre-Gestational and Gestational Diabetes;
- Inadequate glycemic control (i.e., a HbgA1c level of 7.5 or more on two consecutive determinations at least three months apart);
- Change in treatment either from no diabetes medication to any diabetes medication or from oral diabetes medication to insulin;
- High risk for complications based on inadequate glycemic control (i.e., documented acute episodes of severe hypoglycemia or severe hyperglycemia requiring emergency room visits or hospitalization);
- High risk for at least one of the following documented complications: lack of feeling in the foot or other foot complications (e.g., ulcers); pre-proliferative retinopathy or prior laser treatment of the eye; or kidney complications manifested by albuminuria or elevated creatinine;
- Amputation of lower limb for endocrine, nutritional, and metabolic disorders;
- Skin grafts and wound debridement for endocrine, nutritional, and metabolic disorders;
- Nutritional and miscellaneous disorders related to Diabetes with or without co-existing conditions.

It is further agreed that the Program will provide:

- Initial education and training with a Certified Diabetic Educator within a continuous 12-month period;
- Follow up and refresher education and training with a Certified Diabetic Educator in subsequent years when a new prescription is written based on medical necessity;

- Nutritional counseling as a part of the diabetes self-management and education training.

Very truly yours,

CHRYSLER GROUP LLC
By Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By General Holiefield

October 22, 2015

(C-51) Health Care Historical Reference Manual

International Union, UAW

Attention: Mr. Norwood H. Jewell

Dear Sir:

During the course of these negotiations, the parties agreed to create a Health Care Historical Reference Manual which will include, but is not limited to, the following Historical letters:

2011 National Agreement

Letter	Title
C-7	Health Care Quality
C-11	On-Site Physical Therapy
C-17	Control Plan Re-Engineering
C-22	Change Of Address - Retiree/Surviving Spouse
C-24	Improving Benefits Survey Through Technology
C-36	Long Term Care Pilot
C-37	AMC Insurance Program
C-38	AMC Insurance Program - Retirees
C-43	The Kenosha Engine Plant Substance Abuse Pilot
C-47	Wellness Provider

2015 National Agreement

Letter	Title
C-42	PPO Narrow Network
C-44	Request for Proposals

The manual will be jointly developed by the parties and will be made available to the International Union, UAW.

Very truly yours,

FCA US LLC
By: Kathleen Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW
By: Norwood H. Jewell

October 12, 2011

(C-52) Medical Emergency Definition

International Union, UAW

Attention: Mr. General Holiefield

Dear Sirs:

During these negotiations, the Company and the Union discussed the definition of medical emergency.

The parties agreed that the definition of "medical emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The parties further agreed to amend the Program Administrative Manual effective January 1, 2012 to replace the current definition of medical emergency with the definition as described above.

Very truly yours,

CHRYSLER GROUP LLC
By: Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW

By: General Holiefield

October 22, 2015

(C-53) Excise Tax Implications

International Union, UAW

Attention: Mr. Norwood H. Jewell

Dear Sir:

During these negotiations, the parties discussed the application of the Excise Tax on High Cost Employer-Sponsored Health Coverage imposed under the Affordable Care Act on any health plans an employer offers. The parties also discussed that the per-employee dollar limits for these high cost health plans may be modified from time to time by the federal government.

Should any Health Care Plan offered by the Company be expected to exceed the government mandated per-employee dollar limits and be subject to this Excise Tax, the parties will employ a process similar to that used in Letter C-14 to find areas of opportunity to reduce cost. The parties further agree that a member who voluntarily remains in such plan will be subject to a maximum deductible of \$400 for single coverage and \$800 for family. Further, FCA will consult with the UAW National Chrysler Department to ensure that the Excise Tax calculation is conducted in a manner that results in the lowest tax allowable under the law.

Very truly yours,

FCA US LLC

By Kathleen S. Neal

Accepted and Approved:

INTERNATIONAL UNION, UAW

By Norwood H. Jewell

November 20, 2023

(C-54) Major Medical Expense Benefits

International Union, UAW

Attention: Mr. Rich Boyer

Dear Mr. Boyer

During these negotiations the parties agreed that the Major Medical Expense Benefits of the FCA US LLC Life, Disability, and Health Care Benefit Program will continue during the term of this agreement for O&C&E employees hired or rehired prior to April 15, 2010.

Very truly yours,

FCA US LLC
By Christopher Fields

Accepted and Approved:

INTERNATIONAL UNION, UAW

By: Rich Boyer

November 20, 2023

(C-55) Travel and Lodging Benefit

International Union, UAW

Attention: Mr. Rich Boyer

Dear Mr. Boyer:

During these negotiations, the parties discussed the fact that some employees and/or their eligible dependents may not have access to certain highly specialized covered services or procedures based solely on their geographical location. These discussions resulted in the parties agreeing to implement, effective January 1, 2024, or as soon as practicable thereafter, a Health Care Travel and Lodging Reimbursement Program.

The Health Care Travel and Lodging Reimbursement Program provides a total dollar reimbursement amount of \$2,000, per member, per year, if no provider is available in a 150-mile

radius of the employee's home zip code and virtual care is not an option for the following services:

Included Covered Services (to the extent they are covered under the Health Care Plans):

- Abortion
- Behavioral health services
- Cancer treatment
- Cardiac services
- Human organ transplant
- Maternity/reproductive health services
- Musculoskeletal (MSK) procedures
- Rare condition treatment
- Transgender services
- Weight reduction/bariatric procedures

Health Care services listed above only are covered in states where it is legal to perform those services, must be received from a participating in-network provider and require prior authorization, when applicable, before travel is authorized.

Eligibility:

A member must meet eligibility requirements outlined under Exhibit B, Article III.

To receive a reimbursement under the Health Care Travel and Lodging Program, an eligible patient must receive a covered service from a participating in-network provider and obtain a prior authorization, when applicable, in advance of travel being authorized. In addition, the eligible patient must travel a minimum distance of a 150-mile radius from the employee's home zip code when no provider of those services is available within that distance and virtual care is not an option.

Eligible Expenses

Travel may be reimbursed from the eligible employee's home zip code and the location for which the eligible patient receives the covered service. Eligible reimbursable travel expense may be for roundtrip air, train, bus, taxi/ride sharing services or car rental transportation costs.

If driving from the employee's home zip code to the location where the covered service is provided, mileage reimbursement will

be based on the IRS medical mileage reimbursement for the year in which service is received (\$0.22 per mile for 2023). Tolls/parking costs also are reimbursable expenses.

Airfare is limited to commercially scheduled coach class tickets and that cost is applied toward the annual benefit maximum.

Lodging is limited to \$50 per person per night (up to \$100 if a companion travels). Companion travel expense is reimbursable only if the companion's presence is necessary for the member to receive health care services and is limited to one companion.

Exclusions

The Health Care Travel and Lodging Reimbursement Program does not include reimbursement for the following expenses:

- Meals,
- Childcare expenses,
- Alcohol/tobacco,
- Entertainment/souvenirs,
- Expenses for persons other than the patient and their eligible companion,
- Lodging in any location other than a hotel or motel,
- Personal care items (e.g., shampoo, deodorant, toothbrush, etc.),
- Telephone calls,
- Taxes,
- Tips/gratuities,
- Lost wages, and
- Any other expenses similar to those listed here.

Very truly yours,

FCA US LLC
By Christopher Fields

Accepted and Approved:

INTERNATIONAL UNION, UAW
By Rich Boyer

